CCME

2020 External Quality Review

HEALTHY BLUE

Submitted: June 11, 2020

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2020 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Healthy Blue since the 2019 Annual Review.

The goals of the review are to:

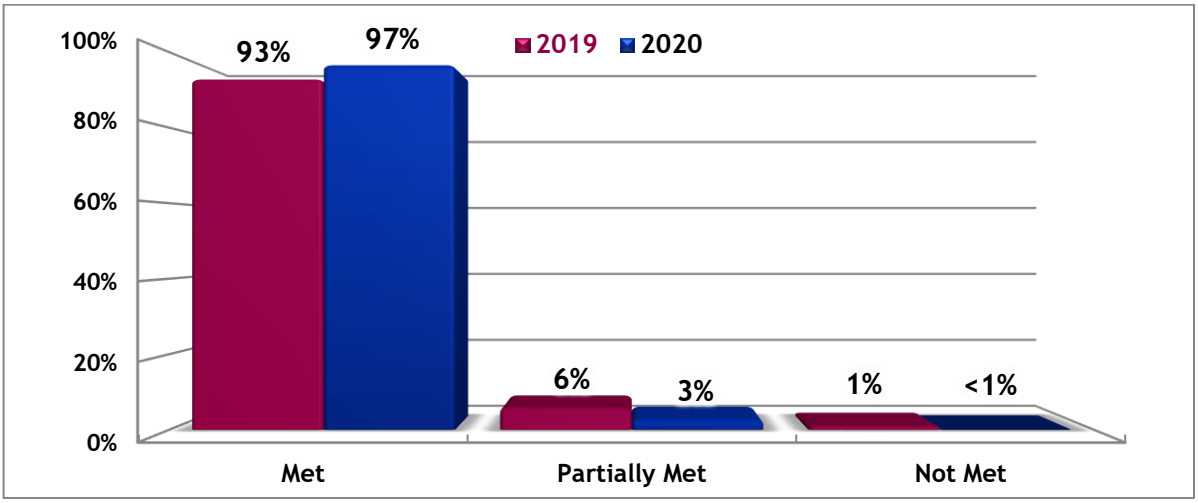
- Determine if Healthy Blue is following service delivery as mandated in the MCO contract with SCDHHS.
- Evaluate the status of deficiencies identified during the 2019 Annual Review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

The process CCME used for the EQR is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day onsite visit, a *Telephonic Provider Access Study*, compliance review, validation of performance improvement projects (PIPs), validation of performance measures, and validation of satisfaction surveys.

Overall Findings

The 2020 annual EQR shows that Healthy Blue achieved a "Met" score for 97% of the standards reviewed. As the following chart indicates, 3% of the standards were scored as "Partially Met," and <1% of the standards scored as "Not Met." The chart that follows provides a comparison of Healthy Blue's current review results to the 2019 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Administration:

Healthy Blue is part of the Blue Cross and Blue Shield Association and partners with Amerigroup Partnership Plan, LLC (Amerigroup) to support the administration of its Medicaid line of business. All key positions are filled, and adequate staffing is in place to conduct all functions.

Appropriate processes are followed for the development, maintenance, and implementation of policies that inform staff of requirements, processes, and related laws and regulations for conducting health plan operations. Policies are reviewed and approved at least annually. Staff are advised of new or revised policies by departmental leadership and via a monthly newsletter. All policies are maintained on a shared drive for staff access.

Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation demonstrates a focus on maintaining the integrity of data and information systems. Security best practices are spelled out in the documentation and document timestamps indicate regular review and revision. Additionally, Healthy Blue appears to have comprehensive programs in place to mitigate business interruptions and help reestablish operations if there is an event that causes an interruption. Healthy Blue meets or exceeds contractual requirements for claims processing.

The Healthy Blue and Amerigroup Partnership Plan Compliance Committee oversees, monitors, and assesses the Compliance Plan. A comprehensive Compliance Plan and Fraud, Waste, and Abuse Plan describe activities to prevent, detect, and respond to violations, with additional information available in topic-specific policies. Initial and

ongoing Compliance and FWA training are provided to all staff. Open communication about compliance and fraud, waste, and abuse (FWA) are encouraged and a no-retaliation policy is in effect for those who report compliance or FWA issues. Internal monitoring and auditing are conducted to identify the need for improvement or corrective action.

Provider Services:

Healthy Blue's Credentialing Committee is chaired by a Medical Director and includes both physician and non-physician clinicians to ensure the use of a peer review process to determine if providers and facilities meet the qualifications, standards, and requirements for participation in the network. CCME could not identify, in review of policies, procedures, and other documentation of provider credentialing and recredentialing processes and requirements, the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers. Discrepancies and omissions of the timeframe for processing provider applications were also noted. Most credentialing files lacked evidence that the Social Security Death Master File (SSDMF) was queried. Healthy Blue explained technical difficulties with obtaining the SSDMF have been ongoing since June 2019. Query of the SSDMF is a contractual requirement and the health plan is encouraged to resolve these issues so that compliance with the requirement can be demonstrated.

Healthy Blue adopts both preventive health guidelines and clinical practice guidelines that incorporate current, evidence-based guidelines from recognized sources. The guidelines are communicated to providers in the Provider Manual and in new provider materials. They are also available on the health plan's website and in paper form upon request.

Geo Access reports are run quarterly to assess network availability and policies define availability and accessibility standards that comply with contract guidelines. Medical Record Compliance Audits are conducted annually and resulted in passing scores from all providers.

CCME conducted a Telephonic Provider Access Study that focused on primary care providers. The 77% answer rate reflects an increase in successful calls that is statistically significant (p=<.001) when compared to results in 2019 of 57%.

Member Services:

Healthy Blue's policies and procedures define and describe member rights and responsibilities, as well as methods of notifying members of their rights and responsibilities. New members receive a New Member Packet with instructions for contacting the Customer Care Center, selecting a primary care provider (PCP), and initiating services. The Evidence of Coverage is Healthy Blue's handbook for members and

will be referred to as the Member Handbook throughout this report. All members have access to information and resources in the Member Handbook, Provider Manual, on the website, and in member newsletters that can help them understand and utilize their benefits. The plan provides a list of preventive health guidelines and encourages members to obtain recommended preventive services.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are conducted annually via a third-party vendor. The 2019 survey response rates continue to fall below the National Committee for Quality Assurance (NCQA) target response rate of 40%.

Grievance requirements and processes are detailed in Healthy Blue policy. Information about grievance filing and handling is included in the Member Handbook and the Provider Manual. The Provider Manual refers the reader to the Healthy Blue website for definitions applicable to grievances, but this information is not found on the website. CCME could not identify that members are informed of the right to file a grievance if he or she disagrees with an extension of the grievance resolution timeframe. Healthy Blue was noted to be noncompliant with the requirement for written consent for a representative to file a grievance on a member's behalf.

The review of grievance files confirmed that, overall, appropriate processes are followed for receiving, resolving, and notifying the grievant of resolution. Isolated issues were noted with timeliness of grievance acknowledgement and resolution. One grievance was created inappropriately but the mistake was not communicated to the member.

Grievance data is used to identify and address trends.

Quality Improvement:

Healthy Blue maintains a Quality Improvement (QI) program with the overall goal to improve the quality and safety of clinical care and services provided to members. The 2020 Medicaid Quality Management Program Description describes this program and includes specific goals and the program's structure, scope, and methodology.

Annually, Healthy Blue develops a QI work plan to guide and monitor activities for the year. The 2019 and 2020 work plans were provided. Each work plan identified specific activities, the responsible party, and specific dates for completion. The descriptions noted in the Objective/Activity column was general and did not contain specific objectives. The work plan referred the reader to the NCQA 2020 HP Standards and Guidelines for complete details and requirements. There was no mention of state requirements. Also, the dates listed in the Specific Date for Completion and the Committee and Schedule Review and Approval Date columns were the same for all activities listed on the work plan.

To evaluate the effectiveness of the QI program, Healthy Blue conducts an evaluation annually. The draft Medicaid Quality Management Program Evaluation for the 2019 Work Plan was provided. The evaluation included results of the quality activities conducted in 2019, any barriers identified, and opportunities for improvements.

Performance Measures and Performance Improvement Projects

Healthy Blue uses Inovalon, a certified software organization, for calculation of HEDIS rates, and the validation found all requirements were met. The comparison from the previous year to the current year revealed a strong increase in Pharmacotherapy Management of COPD Exacerbation, Diabetes Monitoring for People with Schizophrenia, and Use of First Line Psychosocial Care for Children on Anti-Psychotics. There were no measures with a substantial decline of greater than 10%. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial increases in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	Change from 2017 to 2018
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	51.19%	61.46%	10.27%
Bronchodilator	66.88%	79.05%	12.17%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	57.78%	70.15%	12.37%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
Total	53.01%	66.07%	13.06%

Quality Withhold Measures

There are 12 quality clinical withhold measures reported for MY2018 (RY 2019). As per the Medicaid Playbook and *Policy and Procedure Guide for Managed Care Organizations*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by individual measure weights then summed to obtain the quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. Women's Health measure rates

generated the highest index score, followed by Pediatric Preventive Care, and Diabetes and Behavioral Health.

Table 2: Quality Withhold Measures

Measure	MY 2018 Rate	MY 2018 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	85.16%	25	3	2.40
HbA1c Control (< =9)	49.64%	25	3	
Eye Exam (Retinal) Performed	36.74%	<10	1	
Medical Attention for Nephropathy	88.81%	10	2	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	90.08%	90	6	4.10
Breast Cancer Screen	50.95%	25	3	
Cervical Cancer Screen	57.61%	25	3	
Chlamydia Screen in Women (Total)	56.88%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	75.43%	90	6	3.45
Well Child Visits in 3rd,4th,5th&6th Years of Life	63.75%	10	2	
Adolescent Well-Care Visits	51.58%	25	3	
Weight Assessment/Adolescents: BMI % Total	80.29%	50	4	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	38.31%	10	2	2.25
Antidepressant Medication Management Effective Continuation Phase Treatment	32.17%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	66.07%	75	5	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	20.53%	<10	1	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	31.78%	25	3	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	38.48%	25	3	

Healthy Blue submitted two projects for validation. They included Access and Availability of Care and Comprehensive Diabetes Care. Both scored in the "High Confidence in Reported Results" range. *Table 3: Performance Improvement Project Validation Scores* provides an overview of the previous and current review year validation scores.

TABLE 3: Performance Improvement Project Validation Scores

PROJECT	2019 VALIDATION SCORE	2020 VALIDATION SCORE
Access and Availability of Care-Non-Clinical	99% High Confidence in Reported Results	130/131= 99% High Confidence in Reported Results
Comprehensive Diabetes Care-Clinical	100% High Confidence in Reported Results	119/126=94% High Confidence in Reported Results

Utilization Management:

CCME's assessment of utilization management (UM) includes reviews of program descriptions and evaluations, policies, the Member Handbook, the Provider Manual, Healthy Blue's website, and approval, denial, appeal, and case management files. Policies and procedures define how CM services are operationalized and provided to members.

The UM Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Service authorization requests are conducted by appropriate reviewers utilizing Milliman Care Guidelines (MCG) or other established criteria.

The Case Management (CM) Program Description and policies appropriately document case management processes and services provided. Case Management files indicate care gaps are identified and addressed consistently with services provided for various risk levels.

Healthy Blue has an established policy defining processes for handling appeals of adverse benefit determinations. Review of information related to appeals processes and requirements revealed issues with documentation of members' ability to present evidence or review the case file and appeal resolution timeframes. CCME's review of appeal files revealed several instances of staff not following procedures defined in Policy SC_GAXX_051, Member Appeal Process.

Delegation:

All potential delegates are subjected to a pre-delegation assessment of their operations, policies, reporting capabilities, and ability to perform the activities to be delegated. All organizations to whom health plan functions are delegated operate under a written delegation agreement or contract. Annual oversight is conducted of each delegate, including an assessment of the delegate's compliance with accreditation standards, contractual requirements, written policies and procedures, and quality activities related to the delegated functions and activities. In addition to annual oversight, delegates provide reports of activities to the health plan on a predetermined schedule. For any identified deficiencies, a corrective action process is initiated, and the delegate is informed in writing of the corrective action required and the timeframe for completion.

CCME's review of delegate oversight documentation revealed that, overall, appropriate processes are followed; however, the MCO Credentialing File Review Workbooks used to assess credentialing delegates do not indicate delegates are monitored for querying the National Practitioner Databank and National Plan and the Provider Enumeration System.

State Mandated Services:

Provider compliance with provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and required immunizations is monitored through HEDIS measures and medical record reviews conducted by the Quality Department. The 2019 Quality Management Program Evaluation identified EPSDT measures performing below established benchmarks.

Healthy Blue provides all core benefits specified by the *SCDHHS Contract*.

Table 4: Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2019 review.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2019	39	1	0	0	0	40
2020	40	0	0	0	0	40
Provider Services						
2019	72	5	1	0	0	78
2020	76	3	0	0	0	79

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Member Services						
2019	31	2	0	0	0	33
2020	31	2	0	0	0	33
Quality Improvement						
2019	15	0	0	0	0	15
2020	14	0	0	0	0	14
Utilization						
2019	41	4	0	0	0	45
2020	44	0	1	0	0	45
Delegation						
2019	1	1	0	0	0	2
2020	1	1	0	0	0	2
State Mandated Services						
2019	3	0	1	0	0	4
2020	4	0	0	0	0	4

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally-mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On March 16, 2020, CCME notified Healthy Blue that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Healthy Blue to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Healthy Blue on March 30, 2020 and reviewed in CCME's offices (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted via WebEx on May 13th and 14th. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Healthy Blue's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in title *42 of the Code of Federal Regulations (CFR), part 438*, and the Contract requirements between Healthy Blue and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement, "Partially Met," failing a standard, "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4).

A. Administration

The review of the Administration section includes policy and procedure management, staffing, information systems, compliance, program integrity, and confidentiality. Healthy Blue is part of the Blue Cross and Blue Shield Association and partners with Amerigroup Partnership Plan, LLC (Amerigroup) to support the administration of its Medicaid program. Review of Healthy Blue's Organizational Chart and discussion with

health plan staff confirms that all key positions are filled, and adequate staffing is in place to conduct all operations.

Business units develop, maintain, and implement policies to inform staff of requirements, processes, and related laws and regulations for conducting health plan operations. Policies are reviewed and approved at least annually by the Compliance Committee. Staff are advised of new or revised policies by departmental leadership and via a monthly newsletter. All policies are maintained on a shared drive for staff access.

Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation demonstrates a focus on maintaining the integrity of data and information systems. Best practices for security are detailed in the documentation, and document timestamps indicate regular review and revision. Additionally, Healthy Blue appears to have comprehensive programs in place to mitigate business interruptions and help reestablish operations if there is an event that causes an interruption. Documentation confirmed that 90% of claims are processed within 14 days of receipt and 98% are processed within 30 days. This 30-day completion rate is commendable as it is only 1% away from the contractual requirement that 99% of all claims must be complete within 90 days.

The Healthy Blue and Amerigroup Partnership Plan Compliance Committee (Compliance Committee) provides oversight, ongoing monitoring, and assessment of the Compliance Plan. Requirements for compliance with ethical business standards, contractual obligations, and related rules, statutes, and regulations are detailed in the Healthy Blue by Blue Choice Health Plan of South Carolina Compliance Plan. Anthem's Special Investigations Unit Antifraud Plan describes processes for preventing, detecting, and responding to incidents of fraud, waste, and abuse (FWA). Additional information is available in topic-specific policies. Compliance and FWA training are provided to new employees within 30 days of employment and all employees are required to complete annual compliance and FWA training. A no-retaliation policy is in effect for those who report compliance or FWA issues and an "open-door" culture is maintained to encourage communication. Internal monitoring and auditing are conducted to identify needs for improvement or corrective action.

As noted in *Figure 2: Administration Findings*, Healthy Blue achieved scores of "Met" for 100% of the Administration standards.

Figure 2: Administration Findings

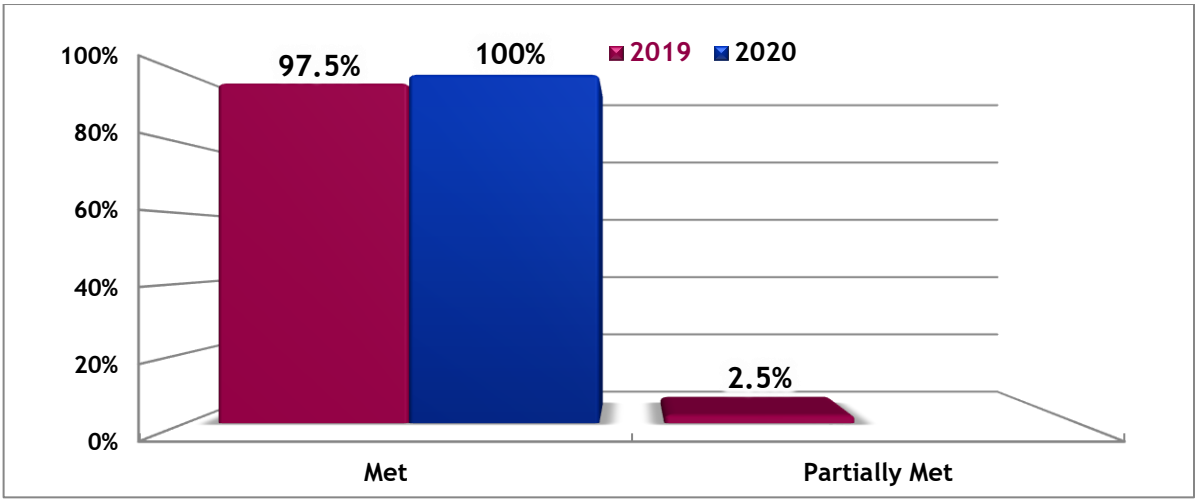


Table 5: Administration Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Compliance/ Program Integrity	The Compliance Plan and/or policies and procedures address all requirements	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- An organizational security program defines security goals and measures necessary to maintain data security.
- Well-developed business continuity and disaster recovery programs have been tested and proven successful.
- The Compliance Plan, FWA Plan, and associated policies comprehensively describe activities and processes used to prevent, detect, and respond to violations of ethical conduct standards and suspected or actual FWA.

Weaknesses

- Discrepancies in membership were noted when comparing the BlueChoice HealthPlan Medicaid and Amerigroup Partnership Plan Compliance Committee Charter to the 2020 Committee Membership List.

Recommendations

- Ensure the BlueChoice HealthPlan Medicaid and Amerigroup Partnership Plan Compliance Committee Charter and the 2020 Committee Membership List reflect consistent information about members of the Compliance Committee.

B. Provider Services

CCME's review for Provider Services includes credentialing and recredentialing requirements and activities, provider network adequacy, provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical record-keeping.

Healthy Blue's Credentialing Committee is chaired by a Medical Director and directs the credentialing program and credentialing activities for medical providers and facilities to ensure they meet the qualifications, standards, and requirements for participation in the network. The Companion Benefit Alternatives Credentialing Committee conducts these activities for behavioral health providers. Membership of the Healthy Blue Credentialing Committee includes an appropriate array of providers with specialties that include internal medicine, pediatrics, pulmonology, obstetrics and gynecology, and surgery. Additionally, membership includes a chiropractor, a dentist, and two nurse practitioners.

CCME's review of policies, procedures, and other documentation of provider credentialing and recredentialing processes and requirements confirmed they are comprehensive and address most requirements. However, the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers was not identified. Also, although Healthy Blue staff stated they process credentialing and recredentialing applications within 30 days of receipt of a completed application, inconsistent or lack of documentation of this timeframe was noted in several documents.

Credentialing files reflect that, overall, appropriate credentialing processes are followed. The only issue identified in the files was lack of evidence that the Social Security Death Master File (SSDMF) was queried. Healthy Blue submitted a memo indicating there have been technical issues with obtaining the SSDMF information since June 2019. Attempts to resolve these issues have been unsuccessful thus far. However, for the files that did contain evidence of the SSDMF query, the queries were conducted after June 2019. No issues were identified in credentialing and recredentialing files for organizational providers.

Policies define availability and accessibility standards that comply with contract guidelines. Providers are informed of accessibility standards in the Provider Manual. Healthy Blue conducts quarterly Geo Access reports to assess network availability.

Documentation reflects distance and drive time standards are met for PCPs within 30 miles or 45 minutes for 90% of the eligible population.

Policy SC-CLLS-018, Cultural and Linguistic Program, gives an overview of Healthy Blue's activities to ensure services and materials are provided to members, including those with limited English proficiency, in a culturally competent manner. The plan maintains culturally- and linguistically-appropriate resources and training modules on the provider website and informs providers of their availability. The resources are extensive, comprehensive, and go beyond the topics of languages spoken and population ethnicity.

Healthy Blue adopts both preventive health guidelines and clinical practice guidelines that incorporate current, evidence-based guidelines from recognized sources. The guidelines are communicated to providers in the Provider Manual and in new provider materials. They are also available on the health plan's website and in paper form upon request.

The plan monitors compliance with medical record documentation standards through the annual Medical Record Compliance Audit (MRCA) which resulted in all providers achieving passing scores above 90%. Inconsistent documentation of the expected passing score was identified in the MRCA report, SQIC minutes dated January 20, 2020, and in Policy SC-QMXX-105, Medical Record Compliance Audit For Documentation. Additionally, the MRCA report reflects a large difference in practice and provider counts from 2018 to 2019; MY2018 had 42 practices with 65 providers and MY2019 had 12 practices with 42 providers. During the onsite teleconference, Healthy Blue staff discussed practice location and size contribute to differences in sample size and explained that the sampling methodology consists of selecting large VIP practices in large "clusters." CCME discussed that selecting large VIP practices and providers can limit the representation of the provider network in the MRCA.

Provider Access and Availability Study

As part of the annual EQR process for Healthy Blue, CCME conducted a Telephonic Provider Access Study focused on primary care providers (PCPs). The Healthy Blue Provider File contained a population of 2,716 primary care providers (PCPs). From that, a random sample of 209 PCPs was selected for the provider access study. PCPs were chosen based on the following criteria: MD, DO, NP, ANP, CFNP, and FNP. The specialties selected were Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Pediatrics. Only Providers located in SC and documented as accepting new patients were selected for the sample. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the contracted providers. Calls were answered successfully 77% of the time (144 of 186) when omitting 23 calls answered by personal or general voicemail messaging services. When compared to last year's results of 57%, the increase in successful answer rate was statistically significant

(p<.001). For those not answered successfully (n=42 calls), 11 (26.2%) were unsuccessful because the provider was not at the office or phone number listed. *Figure 3: Telephonic Provider Access Study Results* provides an overview of the successfully and unsuccessfully answered calls.

Figure 3: Telephonic Provider Access Study Results

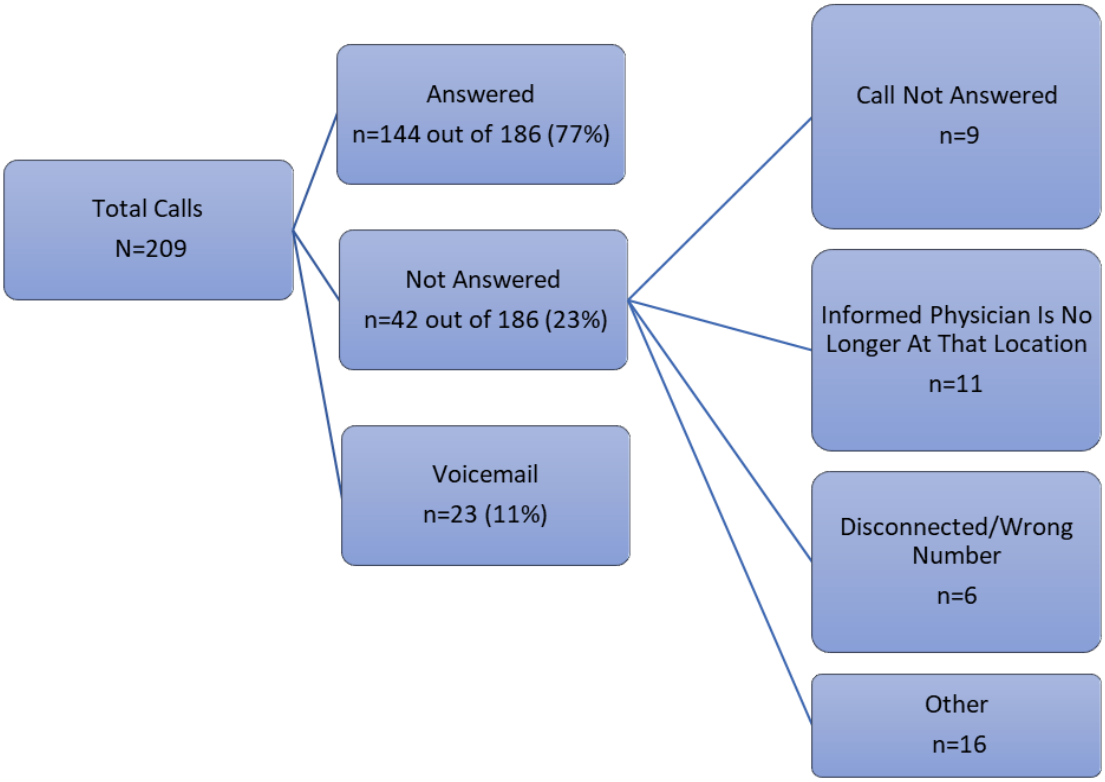
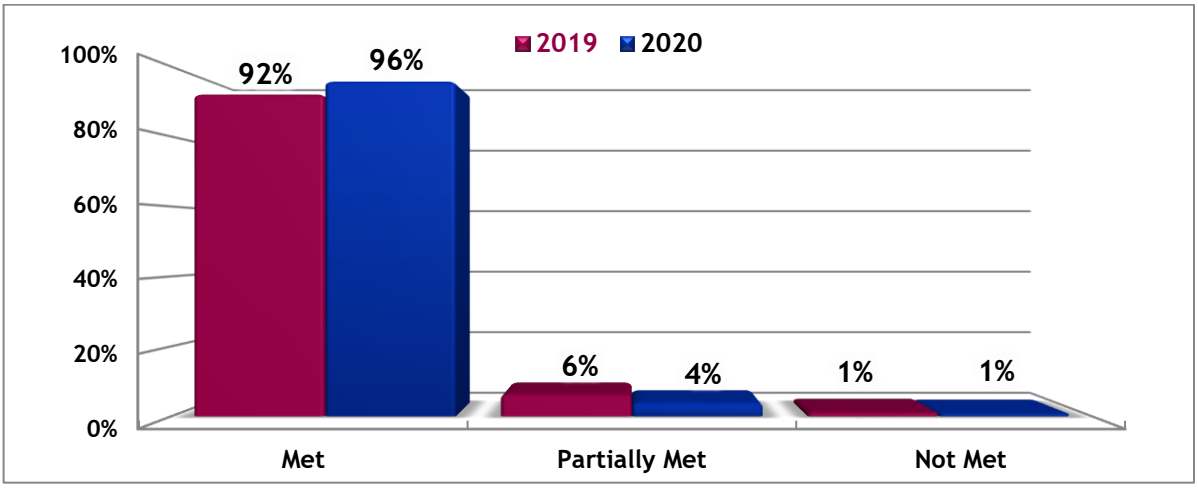


Table 6: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2019 Review	293	57%	<.001
2020 Review	209	77%	

Figure 4: Provider Services Findings shows that 96% of the standards in Provider Services received a "Met" score.

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 7: Provider Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Credentialing and Recredentialing	The credentialing process includes verification of information on the applicant, including: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	Partially Met
	The recredentialing process includes verification of information on the applicant, including: Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Partially Met	Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Met	Partially Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Healthy Blue's Credentialing Committee membership includes both physicians and non-physician clinicians of various specialties to ensure a peer-review process for credentialing and recredentialing of network providers.
- Healthy Blue has extensive and comprehensive cultural competency training resources with topics that go beyond language spoken and population ethnicity.
- The Provider Access Study successful call rate increased significantly from last year when omitting voicemail-answered calls.

Weaknesses

- The process for ensuring all individuals and entities in the provider network are enrolled with SCDHHS as Qualified Medicaid Providers was not identified in credentialing and recredentialing policies or the Credentialing Program Plan. Refer to the *SCDHHS Contract, Section 2.8.1.1.*
- Healthy Blue staff confirmed they process credentialing and recredentialing applications within 30 days from receipt of a completed application. However, the following issues were noted:
  - The Credentialing Plan, page two, references the timeframe as 90 days.
  - Policy MCD-04, page seven, states the timeframe is 60 days for denied applications and does not reference the overall timeframe for approved applications.
  - The timeframe is not documented in Policy MCD – 05 or Policy MCD – 06.
- Initial credentialing files and recredentialing files do not consistently reflect queries of the Social Security Death Master File during the credentialing and recredentialing processes.
- Discrepancies in the passing score for the Medical Record Compliance Audit (MRCA) are documented. Policy SC-QMXX-105, Medical Record Compliance Audit For Documentation, indicates the score is 80% and the 2019 Medical Record Compliance Audit report and CQIC minutes from January 22, 2020 indicate the passing score of 90%.
- The sampling methodology of practices and providers for the MRCA limits adequate representation of the provider network.

Quality Improvement Plans

- Update the credentialing and recredentialing policies or the Credentialing Program Plan to include the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers.

- Ensure the correct timeframe for processing complete credentialing and recredentialing applications is included in the Credentialing Plan, Policy MCD-04, Policy MCD – 05, and Policy MCD – 06.
- Ensure each provider credentialing file and recredentialing file reflects that the Social Security Death Master File has been queried, as required by the *SCDHHS Contract, Section 11.2.10*, and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 11.2*.

Recommendations

- Correct Policy SC-QMXX-105, Medical Record Compliance Audit For Documentation, to reflect the overall performance standard is a score of 90% and ensure consistent documentation of benchmark goals when reporting MRCA results going forward.
- Expand practices and providers for the MRCA to include a variety of practice sizes to be more representative of the Healthy Blue provider network.

C. Member Services

The review of Member Services included policies and procedures, member rights, member informational materials, grievances, and the Member Satisfaction Survey.

Healthy Blue's website has quick links and resources for members to access information such as the Member Handbook, Provider Directory, newsletters, and benefit information. Members receive a New Member Packet with instructions for accessing the Member Handbook, Provider Directory, and member education information.

The draft of the 2020 Member Handbook will notify members of their right to request a copy of the Member Handbook and/or Provider Directory annually. The Member Handbook informs members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and provides instructions on how to access benefits. Additionally, the handbook provides information on obtaining Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. It is available in Spanish and alternate formats including large font, audio, and Braille.

Customer Care Center staff are located in Las Vegas and are available per contract requirements via a toll-free number. The toll-free Member Services telephone number routes calls to Interactive Voice Response (IVR) menus that allow callers to reach appropriate staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Time, Monday through Friday. The toll-free number, fax number, and mailing address are in the Member Handbook and on the website.

Healthy Blue contracts with DSS Research, a certified CAHPS survey vendor, to conduct both the Child and Adult surveys. The 2019 survey results were presented to the Quality Improvement Committee (QIC) and to the providers. The analysis and implementation of interventions to improve member satisfaction is conducted by the QIC. Documentation regarding the committee meetings and analysis was submitted in the desk materials.

Even with oversampling, the Child surveys did not meet the minimum sample size of 411 valid surveys, and the response rate was 17.7%, which is about a 6% decrease from last year. The Adult surveys also used oversampling but had 333 valid surveys with a response rate of 19.3% which was a 7% decrease from last year. The Children with Chronic Conditions (CCC) survey sample was valid for the general population (n=413 surveys) and the total population (n=772). The response rates for CCC were 19.4% for the general population and 19.5% for the total population, which are both lower than last year's response rates.

Despite oversampling, the actual sample sizes were not adequate and did not meet the NCQA minimum sample size and number of valid surveys (at least 411), and the response rates were below the NCQA target of 40%. A new vendor, CSS, will be contracted for the 2020 CAHPS surveys.

Grievance requirements and processes are detailed in Healthy Blue policy. Information about grievance filing and handling is included in the Member Handbook and the Provider Manual. The Provider Manual refers the reader to the Healthy Blue website for definitions applicable to grievances, but this information is not found on the website. Healthy Blue was noted to be noncompliant with the requirement for written consent for a representative to file a grievance on a member's behalf. This requirement is specified in the *SCDHHS Contract, Sections 9.1.1* and *9.1.1.1.2* as well as *42 CFR §438.402 (c) (1) (ii)*.

Grievance resolution and notification timeframes are appropriately documented in policy, the Member Handbook, the Provider Manual. The "Your Grievance and Appeal Rights as a Member of Healthy Blue" document, which is sent as an attachment to grievance letters, does not address extensions of grievance resolution timeframes. Neither the Grievance Extension Notification letter (BSC-MEM-0738-18) nor the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document informs the member of the right to file a grievance if he or she disagrees with an extension of the grievance resolution timeframe. This requirement is found in the *SCDHHS Contract, Section 9.1.6.1.5.2* and *42 CFR §438.408 (c) (2) (ii)*.

The review of grievance files confirmed that, overall, appropriate processes are followed for receiving, resolving, and notifying the grievant of resolution. Isolated issues were noted, including grievance acknowledgement and resolution not within the timeframe specified in policy. One grievance was created in error as a result of a letter from an

attorney and acknowledgement was sent to the member; however, the mistake was not communicated to the member when it was discovered.

Quarterly reports that track and trend grievances are provided to the Service Quality Improvement Committee (SQIC) and used to identify and address trends. CCME's review of SQIC minutes confirms presentation and discussion of grievance reports.

As noted in *Figure 5: Member Services Findings*, Healthy Blue achieved "Met" scores for 94% of the standards reviewed.

Figure 5: Member Services Findings

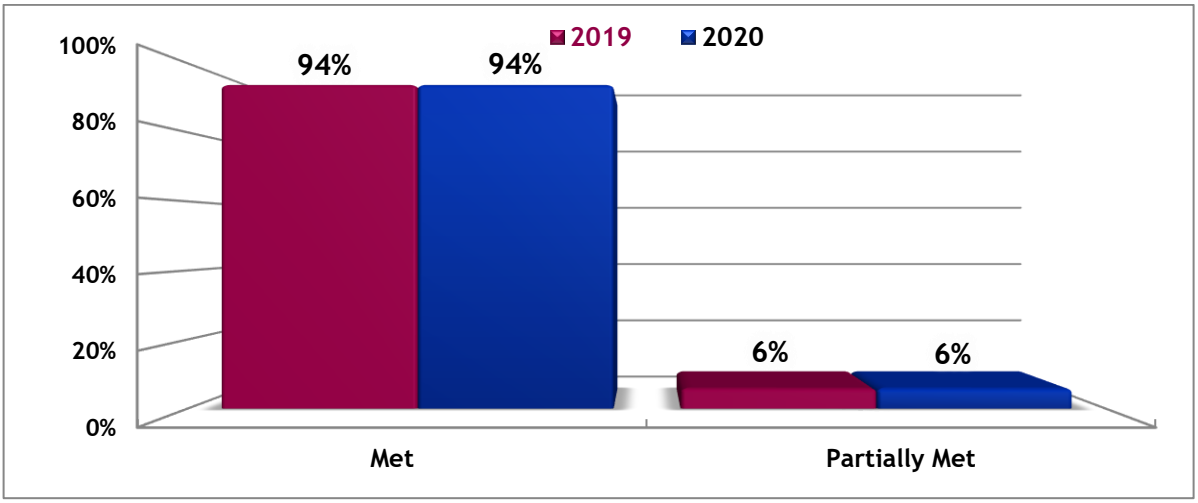


Table 8: Member Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to The definition of a grievance and who may file a grievance	Met	Partially Met
	Maintenance and retention of a grievance log and grievance records for the period specified in the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Healthy Blue has preventive health information and resources geared specifically toward teenaged members.

Weaknesses

- Member rights and responsibilities are not accessible directly on the website.
- Chapter 11 (Member Grievances and Appeals) of the Provider Manual, page 93, states, "For definitions applicable to this section, please refer to Healthy Blue website…" However, the Healthy Blue website does not include a glossary, and the information about grievances on the website does not include definitions of terminology.
- Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document do not address the requirement that written consent is required for a representative to file a grievance on a member's behalf. Discussion during the onsite teleconference confirmed that the health plan does not require written consent for member representation in the grievance process.
- The "Your Grievance and Appeal Rights as a Member of Healthy Blue" document does not address extensions of grievance resolution timeframes.
- Neither the Grievance Extension Notification letter (BSC-MEM-0738-18) nor the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document, which is an attachment to grievance letters, informs the member of the right to file a grievance if he or she disagrees with an extension of the grievance resolution timeframe.
- Grievance file review findings include:
    - Two grievances were not resolved within the 30-day timeframe documented in Policy SC_GAXX_015.
    - One grievance was not acknowledged within the 5-day timeframe documented in Policy SC_GAXX_015.
    - One grievance was created in error in response to a letter from an attorney regarding subrogation for a motor vehicle accident, and an acknowledgement letter was sent to the member. Health plan staff confirmed the member should have been informed the acknowledgement letter was sent by mistake, but this did not occur.

Quality Improvement Plans

- Revise the Healthy Blue website to include definitions of grievance terminology. If not added to the website, revise the Provider Manual to include definitions of grievance terminology.

- Revise grievance processes to include the requirement for written member consent for a grievance to be filed on a member's behalf. Update Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include this requirement. Refer to the *SCDHHS Contract, Section 9.1.1* and *9.1.1.1.2* as well as *42 CFR §438.402 (c) (1) (ii)*.
- Revise the Grievance Extension Notification letter (BSC-MEM-0738-18) or the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include information that a member may file a grievance if he or she disagrees with extension of the grievance resolution timeframe.
- Revise the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include information about extensions of grievance resolution timeframes.

Recommendations

- Place member rights and responsibilities in a prominent location on the website.
- Ensure grievances are acknowledged and resolved within the timeframes documented in Policy SC_GAXX_015.
- If incorrect grievance notices are sent to members, ensure there is follow-up to inform the member of the mistake.

D. Quality Improvement

Healthy Blue maintains a Quality Improvement (QI) program with the overall goal to improve the quality and safety of clinical care and services provided to members. The 2020 Medicaid Quality Management Program Description describes this program with the program's specific goals, structure, scope, and methodology. The program description is updated annually and reviewed and approved by the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC).

Annually, Healthy Blue develops a QI work plan to guide and monitor activities for the year. The 2019 and 2020 work plans were provided. Each work plan identified specific activities, responsible parties, and specific dates for completion. The descriptions noted in the Objective/Activity column were general and did not include the specific objectives. The work plan referred the reader to the NCQA 2020 HP Standards and Guidelines for complete details and requirements. There was no mention of state requirements. Also, the dates listed in the Specific Date for Completion and the Committee and Schedule Review and Approval Date columns were the same for all activities listed on the work plan.

The Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC) have been established to oversee the QI program and activities. A

variety of network providers appointed by the Medical Director and approved by the CQIC and the board of directors serve on the CQIC. Current membership shows six network providers serve on the CQIC. Their specialties include family medicine, OB/GYN, emergency medicine, and pediatrics. A quorum is met with the attendance of three network providers. According to the committee charters, the CQIC and SQIC meet as necessary, but no less than quarterly. Minutes are recorded for each meeting. Documentation reflects committee discussion points and decisions.

To evaluate the effectiveness of the QI program, Healthy Blue conducts an evaluation annually. The draft Medicaid Quality Management Program Evaluation for the 2019 Work Plan was provided. The evaluation included results of the quality activities conducted in 2019, any barriers identified, and opportunities for improvements.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

Healthy Blue uses Inovalon, a certified software organization, for calculation of HEDIS rates, and the validation found all requirements were met. The HEDIS rates for 2018 (Measure Year 2017), 2019 rates (Measure Year 2018), and the change in rates are presented in *Table 9: HEDIS Performance Measure Data*.

Table 9: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	85.40%	87.35%	1.95%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	76.40%	80.29%	3.89%
Counseling for Nutrition	65.45%	67.15%	1.70%
Counseling for Physical Activity	52.80%	62.53%	9.73%
Childhood Immunization Status (cis)			
DTaP	72.99%	75.91%	2.92%
IPV	89.05%	88.08%	-0.97%
MMR	88.56%	88.08%	-0.48%
HiB	85.16%	83.45%	-1.71%
Hepatitis B	88.08%	89.29%	1.21%

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
VZV	88.56%	87.83%	-0.73%
Pneumococcal Conjugate	76.89%	78.10%	1.21%
Hepatitis A	83.94%	83.70%	-0.24%
Rotavirus	70.07%	71.29%	1.22%
Influenza	42.09%	41.85%	-0.24%
Combination #2	69.83%	71.53%	1.70%
Combination #3	67.88%	69.59%	1.71%
Combination #4	65.69%	67.88%	2.19%
Combination #5	56.69%	60.10%	3.41%
Combination #6	37.47%	36.50%	-0.97%
Combination #7	55.47%	59.12%	3.65%
Combination #8	37.47%	36.25%	-1.22%
Combination #9	32.36%	32.60%	0.24%
Combination #10	32.36%	32.36%	0.00%
Immunizations for Adolescents (ima)			
Meningococcal	69.10%	72.02%	2.92%
Tdap	82.97%	83.21%	0.24%
HPV	25.06%	29.68%	4.62%
Combination #1	67.64%	71.29%	3.65%
Combination #2	22.63%	28.71%	6.08%
Lead Screening in Children (lsc)	68.61%	70.32%	1.71%
Breast Cancer Screening (bcs)	51.86%	50.95%	-0.91%
Cervical Cancer Screening (ccs)	58.15%	57.61%	-0.54%
Chlamydia Screening in Women (chl)			
16-20 Years	49.63%	51.96%	2.33%
21-24 Years	62.95%	66.23%	3.28%
Total	54.72%	56.88%	2.16%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	84.17%	84.67%	0.50%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	23.21%	30.25%	7.04%

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	51.19%	61.46%	10.27%
Bronchodilator	66.88%	79.05%	12.17%
Medication Management for People With Asthma (mma)			
5-11 Years: Medication Compliance 50%	54.15%	56.88%	2.73%
5-11 Years: Medication Compliance 75%	26.88%	31.58%	4.70%
12-18 Years: Medication Compliance 50%	51.23%	57.09%	5.86%
12-18 Years: Medication Compliance 75%	24.91%	31.83%	6.92%
19-50 Years: Medication Compliance 50%	50.31%	59.12%	8.81%
19-50 Years: Medication Compliance 75%	26.42%	33.15%	6.73%
51-64 Years: Medication Compliance 50%	66.67%	63.41%	-3.26%
51-64 Years: Medication Compliance 75%	42.42%	51.22%	8.80%
Total: Medication Compliance 50%	53.10%	57.61%	4.51%
Total: Medication Compliance 75%	26.75%	32.74%	5.99%
Asthma Medication Ratio (amr)			
5-11 Years	80.29%	80.04%	-0.25%
12-18 Years	64.97%	71.34%	6.37%
19-50 Years	51.10%	54.73%	3.63%
51-64 Years	54.72%	48.39%	-6.33%
Total	69.02%	70.58%	1.56%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	47.45%	52.80%	5.35%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	70.00%	NA*	NA
Received Statin Therapy: 21-75 Years (Male)	75.63%	77.29%	1.66%
Statin Adherence 80%: 21-75 Years (Male)	57.05%	61.25%	4.20%
Received Statin Therapy: 40-75 Years (Female)	74.23%	72.13%	-2.10%
Statin Adherence 80%: 40-75 Years (Female)	50.00%	57.58%	7.58%
Received Statin Therapy: Total	74.94%	74.87%	-0.07%
Statin Adherence 80%: Total	53.58%	59.59%	6.01%
Effectiveness of Care: Diabetes			

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	84.91%	85.16%	0.25%
HbA1c Poor Control (>9.0%)	48.18%	49.64%	1.46%
HbA1c Control (<8.0%)	42.34%	42.58%	0.24%
Eye Exam (Retinal) Performed	42.82%	36.74%	-6.08%
Medical Attention for Nephropathy	91.73%	88.81%	-2.92%
Blood Pressure Control (<140/90 mm Hg)	50.36%	59.61%	9.25%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	57.94%	61.79%	3.85%
Statin Adherence 80%	45.64%	51.57%	5.93%
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	71.91%	64.29%	-7.62%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	45.07%	46.90%	1.83%
Effective Continuation Phase Treatment	30.08%	32.17%	2.09%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	34.88%	38.31%	3.43%
Continuation and Maintenance (C&M) Phase	46.71%	55.75%	9.04%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	66.67%	NA
6-17 years - 7-Day Follow-Up	NR	35.83%	NA
18-64 years - 30-Day Follow-Up	NR	52.42%	NA
18-64 years - 7-Day Follow-Up	NR	30.30%	NA
65+ years - 30-Day Follow-Up	NR	NA	NA
65+ years - 7-Day Follow-Up	NR	NA	NA
Total - 30-Day Follow-Up	63.51%	56.22%	-7.29%
Total - 7-Day Follow-Up	36.03%	31.78%	-4.25%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NR	61.08%	NA

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
6-17 years - 7-Day Follow-Up	NR	42.09%	NA
18-64 years - 30-Day Follow-Up	NR	41.44%	NA
18-64 years - 7-Day Follow-Up	NR	30.02%	NA
65+ years - 30-Day Follow-Up	NR	NA	NA
65+ years - 7-Day Follow-Up	NR	NA	NA
Total - 30-Day Follow-Up	45.50%	48.66%	3.16%
Total - 7-Day Follow-Up	27.30%	34.46%	7.16%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
30-Day Follow-Up: 13-17 Years	21.21%	NA	NA
7-Day Follow-Up: 13-17 Years	15.15%	NA	NA
30-Day Follow-Up: 18+ Years	15.53%	16.85%	1.32%
7-Day Follow-Up: 18+ Years	10.35%	10.50%	0.15%
30-Day Follow-Up: Total	16.00%	16.46%	0.46%
7-Day Follow-Up: Total	10.75%	10.13%	-0.62%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	74.31%	75.25%	0.94%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	57.78%	70.15%	12.37%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA*	NA*	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	57.47%	64.68%	7.21%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NA*	NA*	NA
6-11 Years	20.27%	17.39%	-2.88%
12-17 Years	21.77%	22.88%	1.11%
Total	22.44%	20.53%	-1.91%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.33%	88.75%	0.42%
Diuretics	87.43%	87.87%	0.44%
Total	87.92%	88.34%	0.42%

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.54%	0.65%	0.11%
Appropriate Treatment for Children With URI (uri)	85.97%	87.75%	1.78%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	29.13%	27.59%	-1.54%
Use of Imaging Studies for Low Back Pain (lbp)	73.88%	67.00%	-6.88%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	NA	NA
6-11 Years	0.00%	0.00%	0.00%
12-17 Years	0.00%	1.10%	1.10%
Total	0.00%	0.68%	0.68%
Use of Opioids at High Dosage (uod)	61.02	5.23%	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	261.62	23.56%	NA
Multiple Pharmacies	58.48	4.72%	NA
Multiple Prescribers and Multiple Pharmacies	26.47	1.89%	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NR	1.99%	NA
18-64 years - >=31 Days covered	NR	1.51%	NA
65+ years - >=15 Days covered	NR	NA	NA
65+ years - >=31 Days covered	NR	NA	NA
Total - >=15 Days covered	NR	1.99%	NA
Total - >=31 Days covered	NR	1.51%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	76.32%	75.57%	-0.75%
45-64 Years	85.56%	85.50%	-0.06%
65+ Years	NA*	NA*	NA
Total	79.00%	78.51%	-0.49%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	96.52%	97.19%	0.67%

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
25 Months - 6 Years	85.19%	86.31%	1.12%
7-11 Years	88.11%	88.40%	0.29%
12-19 Years	85.54%	85.56%	0.02%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	9	NA*	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA*	NA*	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA*	NA*	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA*	NA*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	40.57%	34.41%	-6.16%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	24.53%	22.58%	-1.95%
Initiation of AOD Treatment: 13-17 Years	36.75%	32.00%	-4.75%
Engagement of AOD Treatment: 13-17 Years	22.22%	21.00%	-1.22%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	38.59%	39.57%	0.98%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.20%	9.27%	0.07%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	49.64%	42.15%	-7.49%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	18.98%	22.46%	3.48%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	37.25%	40.65%	3.40%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	11.53%	10.36%	-1.17%
Initiation of AOD Treatment: 18+ Years	38.30%	38.89%	0.59%
Engagement of AOD Treatment: 18+ Years	10.98%	10.95%	-0.03%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	37.88%	39.27%	1.39%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	9.19%	9.60%	0.41%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	49.82%	41.95%	-7.87%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	18.91%	22.49%	3.58%

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	PERCENTAGE POINT DIFFERENCE
Other drug abuse or dependence: Initiation of AOD Treatment: Total	37.60%	40.06%	2.46%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	12.90%	11.52%	-1.38%
Total: Initiation of AOD Treatment: Total	38.19%	38.48%	0.29%
Total: Engagement of AOD Treatment: Total	11.78%	11.55%	-0.23%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	91.09%	90.98%	-0.11%
Postpartum Care	67.82%	70.22%	2.40%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	NA*	NA*	NA
6-11 Years	56.25%	NA*	NA
12-17 Years	55.56%	61.29%	5.73%
Total	53.01%	66.07%	13.06%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.83%	0.97%	0.14%
1 Visit	0.83%	1.46%	0.63%
2 Visits	2.78%	1.22%	-1.56%
3 Visits	4.44%	2.68%	-1.76%
4 Visits	6.39%	7.54%	1.15%
5 Visits	10.56%	10.71%	0.15%
6+ Visits	74.17%	75.43%	1.26%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	65.23%	63.75%	-1.48%
Adolescent Well-Care Visits (awc)	48.66%	51.58%	2.92%

NR = Not Reportable; NA= Not Applicable due to missing data;=small denominator*

The comparison from the previous year to the current year revealed a strong increase in Pharmacotherapy Management of COPD Exacerbation, Diabetes Monitoring for People with Schizophrenia, and Use of First Line Psychosocial Care for Children on Anti-Psychotics. There were no measures with a substantial decline of greater than 10%. *Table 10: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial increases in rate from last year to the current year.

Table 10: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2017	Measure Year 2018	Change from 2017 to 2018
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	51.19%	61.46%	10.27%
Bronchodilator	66.88%	79.05%	12.17%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	57.78%	70.15%	12.37%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
Total	53.01%	66.07%	13.06%

Quality Withhold Measures

There are 12 quality clinical withhold measures reported for MY2018 (RY 2019). As per the Medicaid Playbook and *Policy and Procedure Guide for Managed Care Organizations*, individual measures within quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by the individual measure's weights then summed to obtain the quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 11: Quality Withhold Measures*. Women's Health measure rates generated the highest index score, followed by Pediatric Preventive Care, and Diabetes and Behavioral Health.

Table 11: Quality Withhold Measures

Measure	MY 2018 Rate	MY 2018 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	85.16%	25	3	2.40
HbA1c Control (< =9)	49.64%	25	3	
Eye Exam (Retinal) Performed	36.74%	<10	1	
Medical Attention for Nephropathy	88.81%	10	2	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	90.08%	90	6	4.10

Measure	MY 2018 Rate	MY 2018 Percentile	Point Value	Index Score
Breast Cancer Screen	50.95%	25	3	
Cervical Cancer Screen	57.61%	25	3	
Chlamydia Screen in Women (Total)	56.88%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	75.43%	90	6	
Well Child Visits in 3rd,4th,5th&6th Years of Life	63.75%	10	2	3.45
Adolescent Well-Care Visits	51.58%	25	3	
Weight Assessment/Adolescents: BMI % Total	80.29%	50	4	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	38.31%	10	2	
Antidepressant Medication Management Effective Continuation Phase Treatment	32.17%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	66.07%	75	5	2.25
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	20.53%	<10	1	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	31.78%	25	3	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	38.48%	25	3	

Performance Improvement Project Validation

The validation of the PIPs was done in accordance with the CMS-developed protocol titled, *EQR Protocol 1: Validating Performance Improvement Projects*. The protocol validates project components and its documentation to provide an assessment of the overall study design and project methodology. The components assessed include the following:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Healthy Blue submitted two projects. They included Access and Availability of Care and Comprehensive Diabetes Care. Both scored in the "High Confidence in Reported Results" range. *Table 12: Performance Improvement Project Validation Scores* provides an overview of the previous and current review year validation scores.

TABLE 12: Performance Improvement Project Validation Scores

PROJECT	2019 VALIDATION SCORE	2020 VALIDATION SCORE
Access and Availability of Care- Non-Clinical	99% High Confidence in Reported Results	130/131= 99% High Confidence in Reported Results
Comprehensive Diabetes Care- Clinical	100% High Confidence in Reported Results	120/126=95% High Confidence in Reported Results

The recommendations for last year included initiating or revising interventions for the Access and Availability of Care PIP, as rates were not improving for the adult access to preventive (AAP) services HEDIS measure nor the CAHPS composite measure. The interventions of home visits, automated texting, and enhanced IVR did not improve AAP rates, as they showed a decline. The CAHPS rate did improve. It was noted in the documentation this PIP would be discontinued, although the report noted that access rates would be monitored. The October 2019 CQIC minutes noted that it will be retained. Healthy Blue indicated they did not plan to retire the PIP but to revise the PIP.

For the Comprehensive Diabetes Care PIP, the results for Indicator one appears to be inaccurately reported, as the rate is different at baseline and remeasurement one, but the numerators are the same (349). The remeasurement one numerator needs to be adjusted to reflect the rate. There were no new interventions noted for 2019 and analysis of numbers for 2019 were not included in the report. Healthy Blue provided an updated PIP report; however, there were still some reporting inaccuracies in the updated report. Specific issues and recommendations for correcting the errors identified in the PIPs is displayed in *Table 13: Performance Improvement Project Errors and Recommendations.*

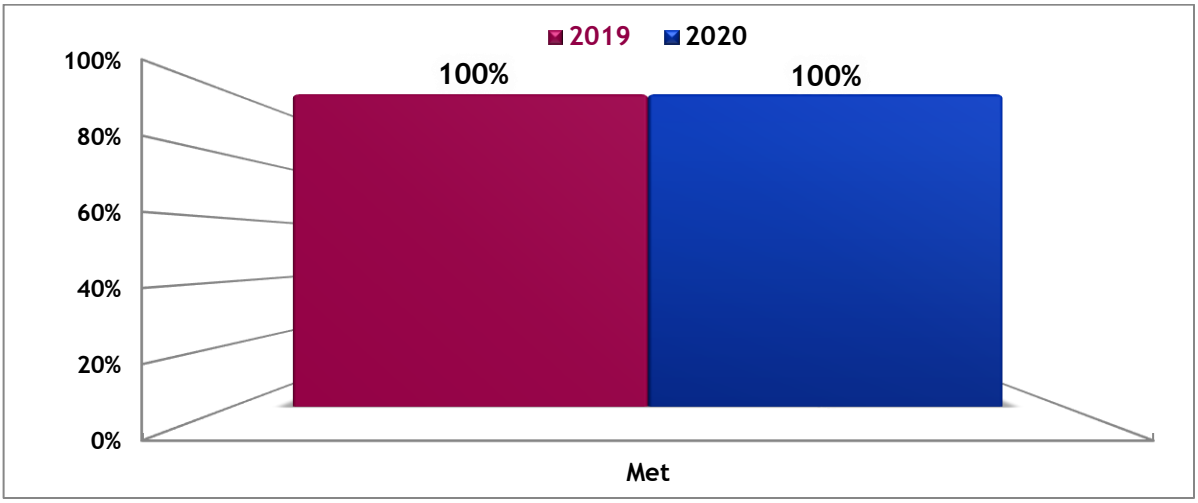
TABLE 13: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Access and Availability of Care	Was there any documented, quantitative improvement in processes or outcomes of care?	Adult access to preventive (AAP) services rate decreased; CAHPS composite measure improved.	Continue to monitor AAP even with pending closure of PIP.
Comprehensive Diabetes Care	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	For indicator #1, the numerator is the same for baseline and remeasurement 1, although the rate is different.	The numerator for remeasurement 1 needs to be adjusted to equal 85.16%. 85.16% is the correct rate, as per the HEDIS report, so numerator needs to be adjusted.
	Was there any documented, quantitative improvement in processes or outcomes of care?	The A1C testing slightly increased but Eye Exam rate decreased. Interventions should be continued to address eye exam rates and A1C testing. The report is not clear on interventions that are active vs interventions that are still in planning phase.	Include information on which interventions are active and which are in planning stages in the report. The best way is to include active interventions in the "Interventions Table" on page 8 and planning-stage interventions in the narrative section on page 11.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Healthy Blue met all the Standards in the QI section. *Figure 6: Quality Improvement Findings* provides an overview of the scores in 2019 compared to the current review scores.

Figure 6: Quality Improvement Findings



Strengths

- The comparison from the previous HEDIS rates to the current rates revealed a strong increase in three measures. There were no measures with a substantial decline of greater than 10%.
- The performance improvement projects scored within the "High Confidence" range.

Weaknesses

- The descriptions noted in the Objective/Activity column of the QI work plan were general and did not contain the specific objectives. Also, the dates listed in the Specific Date for Completion and the Committee and Schedule Review and Approval Date columns were the same for all activities.
- Access to Care PIP report shows that rates for access and availability are decreasing.
- Comprehensive Diabetes Care PIP did not have documentation regarding actions taken during 2019.

Recommendations:

- Include the details and state requirements for each activity listed on the QI work plan. Also, correct the dates of completion for each activity.
- Continue to monitor the adult access to preventive (AAP) services even with pending closure of PIP. Correct the errors noted in the Comprehensive Diabetes Care PIP.

E. Utilization Management

CCME's assessment for utilization management (UM) includes reviews of program descriptions and evaluations, policies, the Member Handbook, the website, and approval, denial, appeal and case management files. The UM Program Description and policies provide guidance to staff conducting UM activities for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina.

Service authorization reviews are conducted by appropriate staff utilizing MCG Criteria and other established criteria and meet timeframe requirements. Review of UM approval and denial files revealed staff consistently follow established procedures and requirements for processing authorization requests. Appropriate peer reviewers issue determinations for requests that cannot be approved on initial review by UM staff.

Healthy Blue's processes for receiving, reviewing, and resolving appeals are documented in policy, the Member Handbook, and the Provider Manual. The Member Appeal Request Form and the Member Appeal Representative Form are available on the member website, although not easily accessible. The member website does not provide instructions or information on appeals.

CCME's review of appeal files found that the appeal resolutions were timely, and appeal resolution letters contained all contractually required components. However, Appeal files reflect staff are not following procedures as outlined in Policy SC_GAXX_051, Member Appeal Process. The following appeal file issues were identified: no signed Appeal Representative Forms, no signed medical record releases prior to sending members' case files, not notifying members when an expedited appeal request is downgraded to a standard request, and a medical necessity file was not reviewed by a physician.

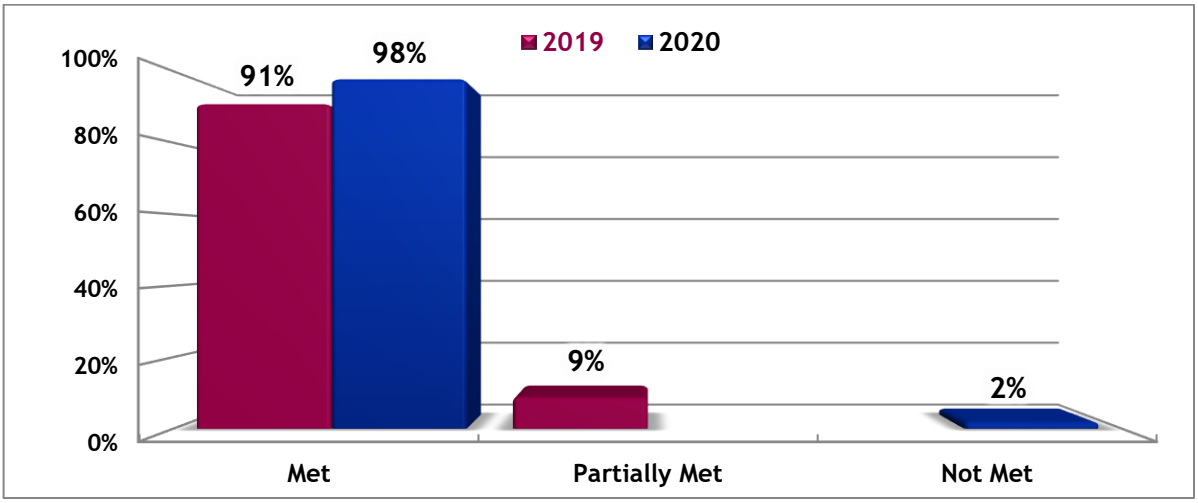
Healthy Blue monitors trends and analyzes appeals data to identify outstanding issues and adverse trends and results are reported to the CQIC and the SQIC.

The Case Management Program Description outlines the framework for the program's goals, scope, and lines of responsibility. Healthy Blue uses case management techniques to ensure comprehensive, coordinated care for all members at various risk levels. CM files indicate case management activities are conducted as required and Case Managers follow policies to conduct the appropriate level of care coordination.

Healthy Blue monitors and analyzes relevant data of potential or actual inappropriate under- or over-utilization which may impact health care services, coordination of care, and appropriate use of services and resources.

As noted in *Figure 7: Utilization Management Findings*, Healthy Blue achieved "Met" scores for 93% of the UM standards.

Figure 7: Utilization Management Findings



Totals may not equal 100% due to rounding

TABLE 14: Utilization Management Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Met
	The procedure for filing an appeal	Partially Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Appeals	Other requirements as specified in the contract	Partially Met	Met
	The MCO applies the appeal policies and procedures as formulated	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Requests for more information are clearly documented when needed before determinations are rendered on service authorization requests.

Weaknesses

- Instructions for obtaining the Surgical Justification Review for Hysterectomy Form HHS-687 from the SCDHHS website are included in the Provider Manual but not on the Healthy Blue website.
- Policy SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care, incorrectly states that the plan will honor prior authorized prescriptions for up to 60 days for new members.
- Policy A08 - Pharmacy Prior Authorization, does not include the requirement that members should not be involved or participate in the resolution of a prescription issue.
- The member website does not provide instructions or information on appeals and the Appeals Representative Form is not posted in an easily accessible location.
- Appeal files reflect staff are not following appeal procedures outlined in Policy SC_GAXX_051, Member Appeal Process. The following issues are identified:
    - Appeal requests submitted on behalf of the member were processed without obtaining signed Appeal Representative Forms, as specified on page 4 of Policy SC_GAXX_051.
    - Expedited requests were processed as standard requests without notifying the member.
    - One appeal file did not include documentation that the appeal was reviewed by or discussed with a Medical Director, as specified in Policy SC_GAXX_051, Member Appeal Process.
    - Member letters mailed with case file documents do not indicate a timeframe or deadline when the member must respond to the plan with additional

information. Case file letters and Appeals Resolution notices were dated within a few days of each other, thus not allowing the member adequate time to respond and present new evidence before the case is resolved.

- Appeal case files were sent to members without documentation that a signed medical record release was obtained.

Quality Improvement Plans

- Ensure staff follow all appeals processes outlined in Policy SC_GAXX_051, Member Appeal Process, such as: obtaining signed Appeal Representative Forms, notifying members when an expedited appeal request is downgraded to a standard request, and ensuring medical necessity files are reviewed and documented by a physician.

Recommendations

- To be consistent with the Provider Manual, include instructions on the provider website for obtaining the Surgical Justification Review for Hysterectomy Form HHS-687 from the SCDHHS website.
- Update Policy SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care, to include that Healthy Blue will honor existing prescriptions needing a prior authorization under the new plan's formulary for a period of no less than 90 days, as specified in *Policy and Procedure Guide for Managed Care Organizations, Section 4.2.21.3.*
- Edit Policy A08 - Pharmacy Prior Authorization, to include the requirement that Healthy Blue will not require the member's involvement or participation in the resolution of a prescription issue related to the issuance of a prior authorization, as specified in *the SCDHHS Contract, Section 4.2.21.3.3.*
- Update the website to include information and instructions on the appeals process and post the Member Appeal Request Form and the Member Appeal Representative Form in a more accessible location on the website.
- Edit case file letters to include a timeframe or deadline when members must respond and present new evidence before the appeals case is resolved.
- Revise Policy SC_GAXX_051, Member Appeal Process, to include the process used by Healthy Blue for mailing all appeal case files to members and obtaining signed medical record release forms. Ensure the documented process specifies the timeframe within which Healthy Blue mails the appeal case files to members.

F. Delegation

Services delegated by Healthy Blue are listed in *Table 15: Delegated Entities and Services*.

Table 15: Delegated Entities and Services

Delegated Entities	Delegated Services
University Medical Associates, Regional Health Plus, Greenville Health System, Vision Service Plan, Roper St. Francis, Dentistat, SC Department of Mental Health, Palmetto Health USC Medical Group, AnMed Health, Bon Secours St. Francis	Credentialing and Recredentialing
CVS CareMark, Express Scripts Inc. (ESI)	Pharmacy Benefit Management

A pre-delegation assessment of is conducted for all potential delegates to assess their operations, policies, reporting capabilities, and ability to perform the activities to be delegated. All organizations delegated to conduct health plan functions operate under a written delegation agreement or contract that specifies:

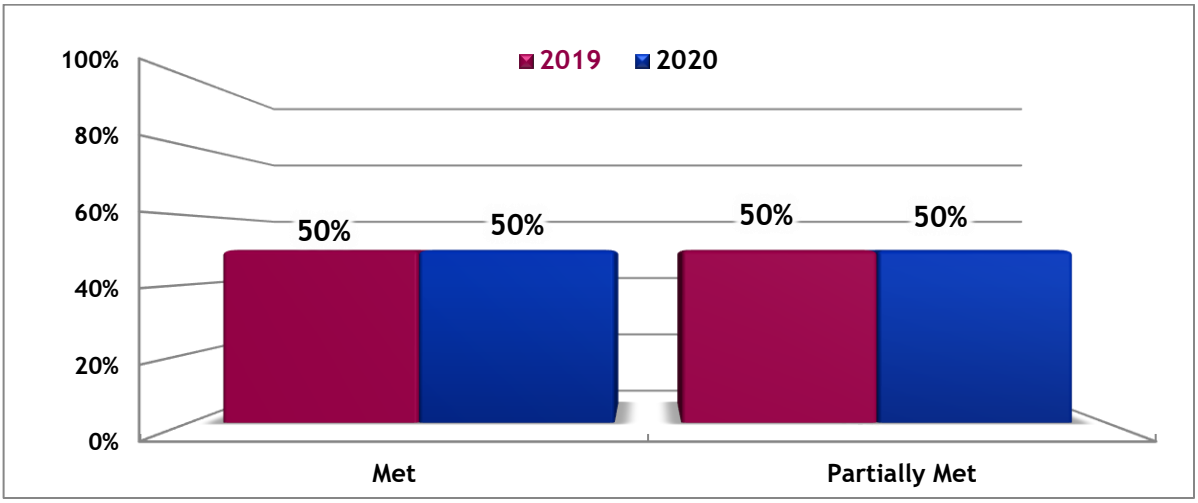
- The delegated activities
- Responsibilities of both the health plan and the delegate
- Reporting requirements
- Information about confidentiality and sub-delegation
- Actions that may be taken in response to substandard or non-performance

Annual oversight is conducted of each delegate. The annual review includes an assessment of the delegate's compliance with accreditation standards, contractual requirements, written policies and procedures, and quality activities related to the delegated activities. For utilization and credentialing/recredentialing activities, the annual oversight includes file review to assess the delegate's compliance with contractual requirements, State and Federal regulations, and accreditation standards. In addition to annual oversight, delegates provide reports of delegated activities to the health plan on a predetermined schedule. If any deficiencies are identified, a corrective action process is initiated, and the delegate is informed in writing of the corrective action required and the timeframe for completion.

CCME's review of delegate oversight documentation confirmed that, overall, appropriate processes are followed. It was noted that the MCO Credentialing File Review Workbooks used to assess credentialing delegates do not indicate whether delegates are monitored for querying the National Practitioner Databank and the National Plan and the Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing.

As indicated in *Figure 8: Delegation Findings*, one of the two standards in the Delegation section is scored as "Partially Met."

Figure 8: Delegation Findings



Weaknesses

- CCME's review of delegate oversight documentation revealed the MCO Credentialing File Review Workbook used to assess credentialing delegates does not indicate whether delegates are monitored for querying the National Practitioner Databank and the National Plan and Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing.

Quality Improvement Plans

- Ensure credentialing and recredentialing delegates are monitored for conducting required queries of the National Practitioner Databank and the National Plan and Provider Enumeration System. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.

G. State Mandated Services

Healthy Blue's EPSDT Program follows the American Academy of Pediatrics periodicity schedule for required screenings and health treatments. The plan monitors compliance with immunization and EPSDT requirements by reviewing primary care provider (PCP) rates for immunization and well-child visits and through medical record reviews. The 2019 Quality Management Program Evaluation identified EPSDT performance measures below established NCQA benchmarks.

Posting EPSDT resources on the website and sending monthly membership lists of missed or upcoming services to providers are examples of how Healthy Blue ensures EPSDT services for members through the month of their 21st birthday.

Healthy Blue provides all core benefits the *SCDHHS Contract* specifies.

As indicated in *Figure 9:* All standards in the *State Mandated Services* section are scored as "Met."

Figure 9: State Mandated Services

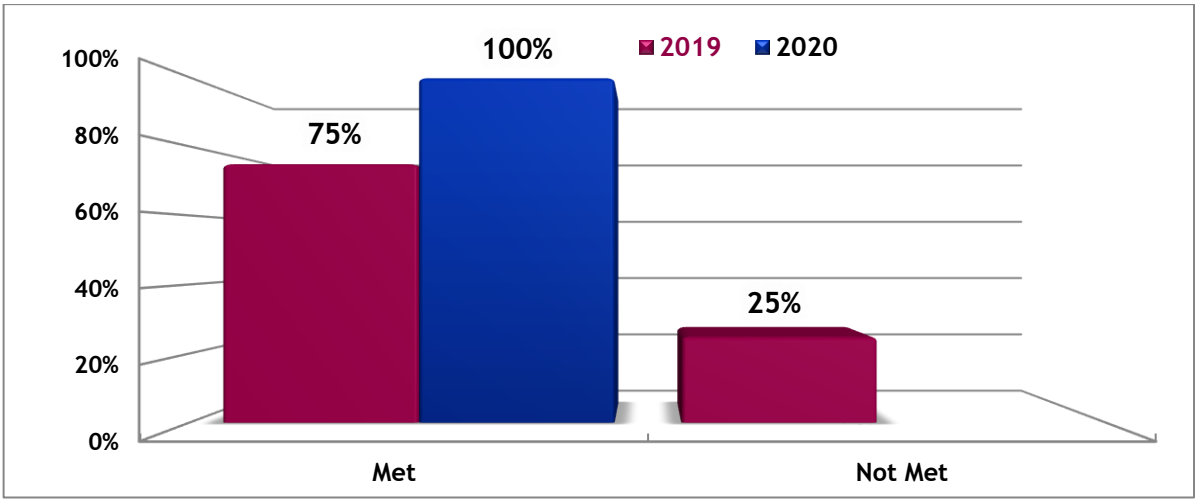


TABLE 16: State Mandated Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
State Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews.	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Weaknesses

- The plan had static or decreased performance in EPSDT services for the W34 Well-Child Visits and AWC Adolescent Well Care Visits measures in 2019.

Recommendation

- Continue to monitor and address barriers contributing to providers not completing required immunization and EPSDT services.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

March 16, 2020

Mr. Daniel Gallagher
Healthy Blue
PO Box 6170, Mail Code AX-400
Columbia, SC 29260-6170

Dear Mr. Gallagher:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2020 External Quality Review (EQR) of Healthy Blue is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **May 13th and 14th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **March 30, 2020.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. **The list should be submitted as an excel spreadsheet in the format listed in the table below**. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2019 and 2020.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from April 2019 through March 2020. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of April 2019 through March 2020.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.
    j. A copy of the claims processing monitoring reports covering the period of April 2019 through March 2020.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report

b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
h. calculated and reported rates. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Provide electronic copies of the following files:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (<u>including signed Ownership Disclosure Forms</u>) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of April 2019 through March 2020. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of April 2019 through March 2020, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://egro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. A copy of the Policy and Procedure Reviews policy (policy number unknown).
3. Additional information for the credentialing and recredentialing files on the attached list.
4. Please send a revised policy index that includes the policy number for each policy listed. Some have the policy name listed in both column A and column B.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PIP:	**ACCESS TO CARE (CLINICAL)**
Reporting Year:	2019
Review Performed:	2020

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Annual preventive care rate was below the HEDIS 50th percentile and rate of getting care is declining.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addressed a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators were related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population as captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling relied upon HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources were noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data as documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection occurrence as noted.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data Analysis will be once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel was listed in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions were documented in the report with new interventions noted in the report.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings were presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and remeasurement data were presented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Follow-up analyses were noted in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Same methodology was used at repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	AAP rate decreased; CAHPS composite measure improved. **Recommendation:** Continue to monitor AAP and other access measures as PIP is revised.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement for CAHPS composite was demonstrated after a one-time decrease in the rate.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Improvement for CAHPS was statistically significant.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not enough remeasurements to verify.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	Study findings verified in HEDIS data file for AAP.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Activity 2	20	20

Project Score	130
Project Possible Score	131
Validation Findings	99%

AUDIT DESIGNATION
High Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PIP:	**COMPREHENSIVE DIABETES CARE (CLINICAL)**
Reporting Year:	2019
Review Performed:	2020

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	A1C screening and eye exam rates were below the HEDIS 50th percentile.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addressed a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators were related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population was captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling relied upon HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources were noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data was documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection occurrence was noted.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data Analysis occurred once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel were listed in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions were documented in the report, however, there were no 2019 interventions included in the report.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	For indicator #1, the numerator was the same for baseline and remeasurement 1, although the rate was different. **Recommendation:** The numerator for remeasurement 1 needs to be adjusted to equal 85.16%. 85.16% is the correct rate, as per the HEDIS report, so numerator needs to be adjusted.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and remeasurements were noted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis for 2018-2020 as offered in the updated report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Same methodology was used at both timepoints.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The A1C testing slightly increased but Eye Exam rate decreased. Interventions should be continued to address eye exam rates and

Component / Standard (Total Points)	Score	Comments
		A1C testing. The report was not clear on interventions that were active vs interventions that were still in the planning phase. **Recommendation:** Include information on which interventions are active and which are in the planning stages in the report. The best way is to include active interventions in the "Interventions Table" on page 8 and planning-stage interventions in the narrative section on page 11.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	The improvement was very slight and information on 2019 interventions was not included in the report, thus, unable to judge.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical significance testing was documented.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not enough timepoints to evaluate for sustainment.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	Study findings verified in HEDIS data file.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	1	1
Step 10		
10.1	NA	NA
Activity 2	20	20

Project Score	120
Project Possible Score	126
Validation Findings	95%

AUDIT DESIGNATION
High Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PM:	**HEDIS**
Reporting Year:	**MY 2018/RY 2019**
Review Performed:	**2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2019 Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation was appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Denominator used correct data sources.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Denominator was calculated accurately.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Numerator used correct data sources.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Numerator was calculated accurately.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Documentation was adequate.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Documentation was adequate.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Documentation was adequate.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Sampling was appropriate.
S2. Sampling	Sample treated all measures independently.	**MET**	Sampling performed appropriately.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Sample size met specifications.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to State/HEDIS specifications?	**MET**	Measures were reported according to HEDIS specifications.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Survey Validation Worksheet

Plan Name	**HEALTHY BLUE**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose was documented. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey was documented. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses were documented. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size was 1,350 according to NCQA and was met. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, were clear and appropriate. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated and implications of response rate were noted. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report* CQIC Meeting Minutes 10/2019

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments and Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allowed for a standardized and audited approach to the implementation and analysis of the surveys. •DSS Research, as a vendor, provided a full report of process and results that met the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 19.26% (n=333 completed surveys) which is below the national average of 21.8%. A low response rate can affect generalizability of the results.
7.4	What conclusions are drawn from the survey data?	The highest scoring items were Customer Service and Getting Care Quickly composites. Several others were in the 75th percentile. The lowest scoring items were Shared Decision Making and How Well Doctors communicate. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the results of CAHPS survey. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *DSS Research 2019 CAHPS® Adult Medicaid Survey Report*

CCME EQR Survey Validation Worksheet

Plan Name	**HEALTHY BLUE**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose was documented. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey was documented. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses were documented. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size was 1,350 according to NCQA and was met. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, were clear and appropriate. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated and implications of response rate were noted. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report* CQIC Meeting Minutes 10/2019

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments and Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allowed for a standardized and audited approach to the implementation and analysis of the surveys. •DSS Research, as a vendor, provided a full report of process and results that met the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 17.73% (but below the national rate of 21.2%; (n=379 completed surveys). A low response rate can affect generalizability of the results.
7.4	What conclusions are drawn from the survey data?	Rating of Personal Doctor had the highest percentile score; Customer Service items were in the lowest percentiles. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the results of CAHPS survey. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *DSS Research 2019 CAHPS® Child Medicaid Survey Report*

CCME EQR Survey Validation Worksheet

Plan Name	**HEALTHY BLUE**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose was documented. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey was documented. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses were documented. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size was 1,350 according to NCQA and was met. Documentation: *D DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and were clear and appropriate. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate were noted. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report* QIC Meeting Minutes Oct 2019

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments and Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allowed for a standardized and audited approach to the implementation and analysis of the surveys. •DSS Research, as a vendor, provided a full report of process and results that met the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The CCC survey sample was valid for the general population (n=413 surveys) and the total population (n=772). The response rates for CCC were 19.4% for the general population and 19.5% for the total population, which are both lower than last year's response rates. A low response rate can affect generalizability of the results.
7.4	What conclusions are drawn from the survey data?	The lowest rated composites were Customer Service and Coordination of Care. The highest composites were Health Promotion and Education, Getting Needed Information, and Rating of Personal Doctor. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the results of CAHPS survey. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *DSS Research 2019 CAHPS® Child CCC Medicaid Survey Report*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Healthy Blue**
Collection Date:	2020

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy MCD-16, Policy Development, Review, and Management describes policy management processes. Each business unit is responsible for developing, maintaining, and implementing policies to comply with state and federal laws, regulations, other regulatory guidance, as well as accreditation and regulatory entities. The Compliance Committee reviews policies at least annually and policies are maintained on a shared drive for staff access. Staff are advised of new

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or revised policies by departmental leadership and via a monthly newsletter.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Healthy Blue's President and Chief Operating Officer is Tim Vaughn.
1.2 Chief Financial Officer (CFO);	X					Jennifer Thorne is the Chief Financial Officer.
1.3 * Contract Account Manager;	X					Amy Bennett is the Contract Account Manager.
1.4 Information Systems personnel;						Marcus Satterfield is the Chief Information Officer.
1.4.1 Claims and Encounter Manager/ Administrator,	X					Leslie Langslow is Amerigroup's Claims and Encounter Manager/Administrator.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Victoria McNeil-Brock is the Director, Health Care Management (HCM). Kimberly Clark is Manager I, Medical Management, over prior authorization and concurrent review. Michael Brownlee is Manager I, Case Management.
1.5.1 Pharmacy Director,	X					Jonathan Jones is the Pharmacy Account Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Director, Quality Management, is Kay Small.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Scott Timmons is Senior Director, Medicaid Contracting and Shay Looker is Manager, Provider Services Staff.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Leticia Lindsay is Member Service Manager. Customer Care Managers include Ashley Lopes and Huong Ly.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Imtiaz Khan is the Medicaid Medical Director. Dr. Kim Cooley is Medical Director and Dr. Jorge Hernandez-Chaple is Behavioral Health Medical Director.
1.10 *Compliance Officer;	X					The Compliance Officer is Rod Johnson.
1.10.1 Program Integrity Coordinator;	X					Debra Teeter serves as the Program Integrity Coordinator.
1.10.2 Compliance /Program Integrity Staff;	X					Billy Quarles is Manager, Compliance.
1.11 * Interagency Liaison;	X					Amy Bennett is the Interagency Liaison

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist or Psychologist;	X					
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation states 90% of claims are processed within 14 days of receipt and 98% are processed within 30 days. Healthy Blue's claim performance standards are: •98% of claims must be processed within 30 days of receipt. •99% of claims must be processed within 90 days of receipt. •All claims must be finalized within 24 months of the date of service, and no adjustments may be made after that date, except in the case of fraud by the provider. •98% accuracy is expected; however, 100% accuracy is achieved the majority of the time. Healthy Blue's 30-day performance is commendable because within 30 days the organization achieves 98% claim completion, which is only 1% away from the SCDHHS contract requirement for 90-day performance (99%).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Healthy Blue's documentation indicates almost all claim and encounter data is exchanged by electronic transactions. Specifically, about 97% of data is handled electronically with only about 3% being submitted in paper form.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Healthy Blue updates eligibility files daily and relies on the state's assigned Medicaid number to track members within its systems. If a situation arises where the state assigns a new/different Medicaid ID to a member, Healthy Blue's systems can consolidate the member's records and reference those records by either ID.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Healthy Blue uses NCQA-certified HEDIS software to create its Medicaid reports. Data stores used for reporting are updated and reviewed monthly to ensure accuracy. Healthy Blue uses a separate data store for HEDIS or HEDIS-like reports, so production processes are not impacted by the reporting processes.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Documentation indicates Healthy Blue follows best practices in managing physical security and electronic data security. Access to facilities and computer systems is assigned in accordance with the principal of least privilege. Additionally, it was noted that routine audits are performed to validate security controls.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Healthy Blue operates under the information security and access management policies and procedures of its partner organization, Anthem. Anthem's "Information Security Program" was included with Healthy Blue's ISCA

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation. The information security program defines and addresses the processes, policies, and procedures the organization follows to protect its data and information systems.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Business continuity and disaster recovery documentation was provided in Healthy Blue's ISCA documentation. The disaster recovery plan is an extensive program that addresses the requirements necessary to reestablish operations if a significant event disrupts business. Similarly, the business continuity plan serves as a good guide to keep operations functioning without interruption. Finally, the results of the last DR test were included and indicates all recovery efforts were successful.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Healthy Blue by Blue Choice Health Plan of South Carolina Compliance Plan (Compliance Plan) addresses requirements for compliance with ethical business standards, contractual obligations, and Medicaid statutes, regulations, and rules. Anthem's Special Investigations Unit Antifraud Plan (FWA Plan) describes processes for preventing, detecting, and responding to incidents of fraud, waste, and abuse (FWA). Topic-specific policies provide greater detail for these areas.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						Principles of ethical business conduct are included in the Compliance Overview and Our

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Values document, as well as in the Compliance Plan and FWA Plan. These rules apply to all associates, management, officers, and directors of BlueCross BlueShield of South Carolina and its subsidiaries.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						The Compliance Plan and FWA Plan describe compliance and FWA training provided to staff. New employees must complete an initial training within the first 30 days of employment and all employees are required to complete annual compliance and FWA training. New provider orientation includes FWA and the False Claims Act. Providers and subcontractors are informed of the consequences of being a participant in or contributing to FWA.
2.6 Lines of communication;						Healthy Blue and Anthem communicate expectations for regulatory compliance and business conduct to employees. Staff are assured there will be no retaliation for inquiring about or reporting compliance and FWA issues. Management staff are expected to foster an “open-door” culture that encourages communication. Staff can also contact the Compliance Officer with any questions or concerns they may have.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Enforcement and accessibility;						The Compliance Plan ensures a consistent approach to resolving Compliance issues. Policies and procedures are monitored and enforced through disciplinary actions that range from education and training through termination for employees, and sanctions, recoupment of payments, or contract termination for providers. The Compliance Plan provides examples of conduct which would be subject to disciplinary action or sanction. A “zero tolerance” policy is maintained regarding any conduct that would negatively impact Healthy Blue’s mission, operation, or reputation.
2.8 Internal monitoring and auditing;						Healthy Blue conducts risk assessments and develops metrics for monitoring and auditing performance, which help to identify areas that need improvement or corrective action. Findings and observations of risk assessments are included in a report which is shared with applicable business units. The business units develop corrective action plans to address observations and findings. The risk assessment findings, observations, and corrective action plans are reported to the Compliance Committee and executive staff.
2.9 Response to offenses and corrective action;						Potential Compliance issues are evaluated to determine if enough information is available to begin an investigation. If so, Compliance staff begin the investigation and may get support from or assign the investigation to another department. The Compliance Officer may engage the services of outside counsel or other

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						independent subject matter experts to conduct or support an investigation. If the investigation confirms a regulatory deficiency, the Compliance Officer or designee works with senior management to develop a corrective action plan which may include, but is not limited to: •Repayment of funds •Disciplinary action •Procedure or systems changes •Disclosure of the deficiency to one or more government agencies, where required •Notification of Anthem's Chief Compliance Officer, Medicaid Compliance Committee, and the Audit Committee, if appropriate
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						Processes for monitoring the exclusion status of subcontractors, persons with an ownership or control interest, and agents or managing employees of the health plan are documented in the Compliance Plan. Healthy Blue conducts pre-employment background checks on all potential employees, providers, and contractors and reviews federal and state exclusion databases to ensure they are eligible to participate. Monthly checks of federal and state exclusion databases are conducted after the initial check. According the Compliance Plan, the queries conducted include the System for Award Management

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						(SAM), Office of Inspector General's List of Excluded Individuals/Entities (LEIE), State Exclusion Lists, and SCDHHS Program Integrity websites. Policy SC_PNXX_309, Excluded and Debarred Providers - Healthy Blue℠ states Healthy Blue and Amerigroup verify all subcontractors, at contracting and then monthly, against the National Practitioner Data Bank, LEIE, SAM, SCDHHS' Excluded Providers' Spreadsheet, the State Board of Medical Examiners, Social Security Administration's Death Master File (SSDMF), SC List of Providers Terminated for Cause, and the CMS Adverse Action Report. Discussion with staff and additional information provided confirms a pre-employment background screen is conducted by HireRight and includes a Social Security Number verification and trace, including the SSDMF. Additionally, a rescreening of these elements is conducted annually.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Healthy Blue and Amerigroup Partnership Plan Compliance Committee (Compliance Committee) provides oversight, ongoing monitoring, and assessment of the Compliance Plan. The committee is chaired by Healthy Blue's Compliance Officer and meets quarterly with additional meetings held if necessary. The quorum is defined as three members from each organization.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The BlueChoice HealthPlan Medicaid and Amerigroup Partnership Plan Compliance Committee Charter for this committee defines the membership, which includes staff from both Healthy Blue and Amerigroup. However, discrepancies were noted when comparing the charter to the 2020 Committee Membership List provided in the desk materials. *Recommendation: Ensure the BlueChoice HealthPlan Medicaid and Amerigroup Partnership Plan Compliance Committee Charter and the 2020 Committee Membership List reflect consistent information about members of the Compliance Committee.*
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy SC_PMXX_025, Medicaid Pharmacy Lock-In Program, describes the processes implemented to comply with the requirements of the *SCDHHS Contract, Section 11.10.*
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy MCD-09, Privacy and Confidentiality, states new employees, consultants, and contractors must attend "Our Values" training

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						which includes an overview of Health Insurance Portability and Accountability Act, defines protected health information (PHI), and defines impermissible uses or disclosures of PHI. The policy indicates all new employees must complete this training before any access to PHI is granted.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				Processes for provider credentialing and recredentialing are found in the Healthy Blue Credentialing Program Plan (Credentialing Plan), Policy MCD – 04, Initial Credentialing, Policy MCD – 05, Recredentialing, and Policy MCD – 06, Health Care Delivery Organizations – Credentialing / Recredentialing. During review of these

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documents, CCME could not identify the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers. Refer to the *SCDHHS Contract, Section 2.8.1.1.* Discussion with Healthy Blue staff revealed the timeframe for processing credentialing and recredentialing applications is within 30 days of receipt of a completed application. Regarding this timeframe, the following issues were noted: •The Credentialing Plan, page 2, references the timeframe as 90 days. •Policy MCD-04, page 7, states the timeframe is 60 days for denied applications and does not reference the overall timeframe for approved applications. •The timeframe is not documented in Policy MCD – 05 and Policy MCD – 06. *Quality Improvement Plan: Update the documents above to include the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers. Ensure the correct timeframe for processing complete credentialing and recredentialing applications is included in the Credentialing Plan, Policy MCD-04, Policy MCD – 05, and Policy MCD – 06.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Credentialing Committee directs the credentialing program and credentialing activities to ensure providers and facilities are competent and meet the qualifications, standards, and requirements for participation in the Healthy Blue provider network. The Companion Benefit Alternatives Credentialing Committee conducts these activities for behavioral health providers. The Healthy Blue Credentialing Committee is chaired by a Medical Director and membership includes five network physicians with specialties in internal medicine, pediatrics, pulmonology, obstetrics and gynecology, and surgery. Additionally, membership includes a chiropractor, a dentist, and two nurse practitioners. CCME's review of committee minutes confirmed the quorum was met for each of the meetings submitted for review.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files reflect that, overall, appropriate credentialing processes are followed. One issue was identified and is addressed in the standards below.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);		X				Of 16 initial provider credentialing files, only three contained evidence that the Social Security Death Master File (SSDMF) was queried. Healthy Blue submitted a memo indicating there have been technical issues with obtaining the SSDMF information since June 2019. Attempts to resolve these issues have been unsuccessful thus far. However, for the three files that did provide evidence of querying the SSDMF, the queries were conducted after June 2019. *Quality Improvement Plan: Ensure each provider credentialing file reflects that the SSDMF has been queried, as required by the SCDHHS Contract, Section 11.2.10, and the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 11.2.*
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Ownership Disclosure form.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files reflect that, overall, appropriate credentialing processes are followed. One issue was identified and is addressed in the standards below.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);		X				Of 17 recredentialing files for providers, only three contained evidence that the Social Security Death Master File (SSDMF) was queried. Healthy Blue submitted a memo indicating there have been technical issues with obtaining the SSDMF information since June 2019. Attempts to resolve these issues have been unsuccessful thus far. However, for the three files that did provide evidence of querying the SSDMF, the queries were conducted after June 2019.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure each provider recredentialing file reflects that the SSDMF has been queried, as required by the SCDHHS Contract, Section 11.2.10, and the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 11.2.
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy MCD-05, Recredentialing, includes that ongoing monitoring of practitioners will occur through monitoring of sanctions, member complaints, and quality issues. The Healthy Blue Credentialing Program Plan also addresses this by stating "Credentialing staff perform ongoing monitoring of provider network participants continuing compliance with criteria for network participation and document, investigate and report in cases where a participating provider ceases to comply with the criteria. All data

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						collected is presented to the Credentialing Committee for review and recommended action." Review of credentialing committee minutes reflects this information is provided at recredentialing.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					Policy MCD-06, Health Care Delivery Organizations Credentialing/Recredentialing, describes credentialing and recredentialing processes for hospitals, skilled nursing facilities/nursing homes, freestanding surgical centers, home health care agencies, and facilities that provide inpatient, residential, and ambulatory mental health and substance abuse services. Credentialing and recredentialing files reflect that Healthy Blue confirms organizational providers are accredited and/or licensed by appropriate authorities.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy MCD-11, Medicaid Access/Availability Standard, defines the method used to monitor network adequacy for the type, number and geographic distribution of primary care providers, specialists, and behavioral health practitioners. The 2019 Provider Network Adequacy Assessment: Accountability Assessment Report, reflects Healthy Blue meets distance and drive time standards for PCPs for 90% of the eligible population in all counties.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MCD-11, Medicaid Access/Availability Standard correctly define access standards for High-Volume Specialists, including behavioral health providers and hospitals as one within 50 miles/75 minutes for 95% of the members.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Healthy Blue submits bi-annual network reports to SCDHHS as defined in Policy MCD-11, Medicaid Access/Availability Standard. The 2019 Quality Management Program Evaluation indicates all network adequacy performance goals were met.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Healthy Blue analyzes the provider network in accommodating members' cultural, racial, ethnic and linguistical needs, as reported in the 2019 Cultural Needs Assessment. Policy SC-CLLS-018, Cultural and Linguistic Program, describes how Healthy Blue ensures culturally and linguistically appropriate health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						care services to all members, including but not limited to, those with limited English proficiency, low-level reading skills, hearing, speech, and/or visual impairments, members with diverse cultural and ethnic backgrounds, and the homeless. The provider education website has an extensive cultural competence training program that includes the Caring for Diverse Populations toolkit, a Cultural Competency training presentation, and a link to My Diverse Patients training website.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The 2019 QM Work Plan Evaluation indicates the plan exceeded the PCP availability goal of 95% in 2019 and there were no improvement actions required.
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					
3.Practitioner Accessibility						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					The plan annually monitors member access to primary care services, behavioral health services, high-volume/high-impact specialists, and emergency care as defined in Policy MCD-11, Medicaid Access/Availability Standards. Providers are informed of the appointment availability standards in the Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Results of MY2018 access and availability monitoring for medical and behavioral health providers are reported in the 2019 Healthy Blue Practitioner Access Analysis and the 2019 Companion Benefit Alternatives Medicaid Practitioner Survey Quality Improvement Activity Report, respectively.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					The results of the Telephonic Provider Access Study conducted by CCME reflect calls were answered successfully 77% of the time (144 of 186) when omitting 23 calls answered by personal or general voicemail messaging services. When compared to last year's results of 57%, this year has an increase in successful calls that is statistically significant (p<.001). For those not answered successfully (n=42 calls), 11 (26.2%), calls were unsuccessful because the phone was not answered or went to a busy signal. Of the 103 who answered the question regarding accepting Healthy Blue, 65 (63.1%) of the providers indicated they accept new Healthy Blue patients, and 38 (36.9%) said they were not currently accepting new patients. Of 40 providers who responded to the question regarding a screening process for new patients, 24 (60%) reported there is a screening process, and 16 (40%) reported that there is no screening process for new patients. Of the 24 that do require screening, 4 (16.7%) require an

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						application, 6 (25%) require a medical record review, 11 (45.8%) require both an application and a medical record review, and 3 (12.5%) require other information such as insurance card information, medical history questionnaire, or information on previous doctors from which care was received. It should be noted that this study was conducted during the COVID-19 stay-at-home orders in South Carolina.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Per policy MCD-01, Education of Contracting Providers, on-site education is scheduled with each office when the contract is signed.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing education is held at least once a year in four regional locations. In addition, on-site visits and educational workshops are held on an as needed basis.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring, states Amerigroup approves for adoption the preventive health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines (PHGs) to incorporate current, evidence-based guidelines from recognized sources. The policy describes processes used to review, revise, and adopt PHGs, as well as to ensure they comply with state contractual requirements.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Amerigroup works with Healthy Blue to post the PHGs on its Medicaid provider website. The Provider Manual also includes information about the PHGs and where to locate on the website. Newly contracted providers are informed of the PHGs in welcome materials.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy SC_QMXX_048, Clinical Practice Guidelines - Review, Adoption and Distribution, states Amerigroup, on behalf of Healthy Blue, reviews and approves medical and BH clinical practice guidelines (CPGs) that are relevant to membership needs and assists in decision-making about health care services. The CPGs are updated annually and as needed for changes to national guidelines.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					Following adoption by the CQIC, the CPGs are disseminated to participating providers and are available on Healthy Blue's website. New providers are informed of the CPGs through their welcome materials, and information about the guidelines is found in the Provider Manual. The guidelines are posted on the Healthy Blue website and written copies are available upon request.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Annually Healthy Blue monitors continuity and coordination of medical care movement across settings and practitioners. The Draft 2019 Quality Management Program Evaluation provided an overview of the measures that are monitored,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						results, and actions planned to improve coordination of care.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy SC-QMXX-105, Medical Record Compliance Audit For Documentation Standards, outlines the methodology Healthy Blue uses to monitor and evaluate PCP compliance with documentation standards in member medical records. Information about the medical record audit is provided in the Provider Manual. CCME identified discrepancies in the expected passing score for the Medical Record Compliance Audit (MRCA). Policy SC-QMXX-105, Medical Record Compliance Audit For Documentation states, "The overall performance standard is a cumulative score of 80%." However, the 2019 Medical Record Compliance Audit report and CQIC minutes from January 22, 2020 indicate practices are expected to achieve a minimum passing score of 90%. During the onsite, teleconference Healthy Blue confirmed the passing score for the MRCA is 90%. *Recommendation: Correct Policy SC-QMXX-105, Medical Record Compliance Audit For Documentation, to reflect the overall performance standard score of 90%. Going forward, ensure consistent documentation of benchmark goals when reporting MRCA results.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The 2019 Medical Record Compliance Audit consisted of 42 individual providers representing 12 practices with each achieving a passing score. CCME identified a large difference in practice and provider counts from 2018 to 2019. Year 2018 had 42 practices with 65 providers and 2019 had 12 practices with 42 providers. During the virtual onsite, Healthy Blue revealed practices and provider offices for the annual MRCA are selected from large VIP practices in large "clusters" which helps in assuring an adequate sample of records for the audit. Additionally, auditing large practices are more efficient for the review staff. CCME discussed that selecting large VIP practices and providers limits the representation of the provider network and recommended that Healthy Blue revisit the sampling methodology to include a variety of practice sizes. *Recommendation: Expand practices and providers for the MRCA to include a variety of practice sizes to be more representative of the Healthy Blue provider network.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Healthy Blue ensures member rights and responsibilities as described in Policy SC_ QMXX_104, Member Rights and Responsibilities. Members are informed of their rights in the Member Handbook. Additionally, members can obtain information from the Customer Care Center and providers are notified of member rights and responsibilities in the Provider Manual.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in Policy SC_ QMXX_104, Member Rights and Responsibilities, the Member Handbook, and Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						However, Member rights and responsibilities are not accessible directly on the website. The following instructions are given in the Member Handbook section on the website, "Your member handbook (Evidence of Coverage) is your go-to guide for health services. Read it to find out about: Your rights and responsibilities as a Healthy Blue member". *Recommend: Place member rights and responsibilities in a prominent location on the website.*
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Policy SC_COXX_126, Annual Notification to Members, states members are provided a New Member Packet within 14 days of Healthy Blue receiving the member's enrollment data from SCDHHS. It includes directions to access or request a Member Handbook and a Provider Directory from the website.
1.1 Benefits and services included and excluded in coverage;						The Member Handbook, page 12, includes a benefit quick reference guide that briefly describes covered services with applicable limits and exclusions. Additionally, benefit information is noted throughout the Member Handbook and on the website. Members can also contact the Customer Care Center to obtain this information.
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						A table listing copayments and limits of coverage are in the Member Handbook, Provider Manual, and on the website. Copayments do not apply to children younger than 19 years old, pregnant women, or institutionalized individuals. Services not covered by Healthy Blue are clearly listed in the Member Handbook, as well as on page 19 of the Provider Manual.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The process and requirements for prior approval on medical, behavioral health (BH) and pharmaceutical services is described in the Member Handbook. Services that require prior approval are indicated in the table of covered services. Prior approval is not required for family planning services, emergency visits, or BH. Additionally, services that require prior authorization are clearly listed throughout the Provider Manual.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The Healthy Blue website provides clear and specific information instructing members on the appropriate level of care for a routine, urgent, or emergent healthcare need.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The Member Handbook includes information about obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and find participating pharmacies or to contact the Customer Care Center to obtain this information.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						Updates to the Preferred Drug List (PDL) are documented in Pharmacy Member Formulary Change Notice which is accessible on the website and appropriately dated to indicate the effective dates. Policy SC_PNXX_303, Provider Termination and Member Notification, states Healthy Blue will send written notice at least 15 days of becoming aware of the PCP's termination from the network.
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The Member Handbook provides instructions for members to change their PCP by contacting the Customer Care Center or filling out the PCP Selection Form found within the Member Handbook.
1.11 Procedures for disenrolling from the MCO;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The Member Handbook informs members to use the online Provider Directory or call the Customer Care Center to obtain information about providers. A searchable Provider Directory is available on the website and members can request a paper copy.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						The Member Handbook and website indicate Healthy Blue provides free interpreter and translation services to members who speak other languages or have limited English proficiency. Written materials in alternative formats, such as large print or simple language, can be obtained by calling the Customer Care Center.
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						The Member Handbook provides necessary information on how to use the ID Card to obtain services.
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						A description of the Customer Care Center, the toll-free number, and the mailing address are in the Member Handbook and on the website. Members have to ability to send secure messages through the member portal after creating an account.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Member Handbook, Provider Manual, and website provide information about EPSDT services and include a schedule of recommended services from birth through 21 years of age.
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					The 2020 Member Handbook draft version states, "You have the right to request a copy of your EOC and/or the provider directory every year at no charge. You can request these materials by calling the <Customer Care Center> number listed below." During the onsite teleconference, Healthy Blue explained members receive an annual written notice informing them of this right.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Policies SC_COXX_126, Annual Notification to Members, and SC_PNXX_303, Provider Termination and Member Notification, indicate Healthy Blue notifies members in writing within 15 days after a receipt of a provider's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						termination from the network and at least 30 days before the effective date of a change in benefits.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy SC_MKXX_012, Member Materials Development and Translations, defines requirements for member program materials and states member materials are written no higher than a sixth-grade reading level using the Flesch-Kincaid method to determine readability. Twelve-point font is used for regular print member materials and large-print materials are printed no smaller than 18-point font.
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					Policy SC_CSPC_002, Customer Service, describes the requirements for Customer Care Center operations. The Customer Care Center is located in Las Vegas and is staffed Monday through Friday from 8 a.m. to 6 p.m. Outside of the normal business hours, the Interactive Voice Response (IVR) system instructs to call 911 or go to the nearest Emergency Room (ER) for life-threatening emergencies. Callers are given the option to leave a message to which a response is provided within one business day. The TTY number for the Customer Care Center and the 24-hour Behavioral Crisis Hotline are published in the Member Handbook and made available for members. The 24-Hour Nurseline is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						available to provide medical advice 24 hours a day via a toll-free telephone number.
III C. Member Enrollment and Disenrollment						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Page 11 of the Member Handbook describes the process for members to choose a PCP. Members can select one PCP for all members of the family or choose different PCPs, as appropriate, for their needs. Healthy Blue will assign a PCP if the member has not selected one within the required timeframe.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy SC_UMXX_125, Termination of Membership, states Healthy Blue must request member disenrollment in writing to SCDHHS. SCDHHS Is responsible for disenrollment actions to remove a member from the plan. Requests for member disenrollment cannot be for an adverse change in health status, utilization of medical services, diminished mental capacity, or disruptive behavior related to the member's special needs.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members are informed of scheduled preventive health services, available case management programs, and how to obtain educational support for medical, behavioral health, and pharmaceutical services on the website, Member Handbook, and via member newsletters. Health information is available for all members in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						various age groups and incentives are offered for members to participate in the recommended services through the Healthy Rewards Program.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, describes how Healthy Blue monitors members for EPSDT services. Information about the EPSDT/Well-Child program is communicated in the Member Handbook, Provider Manual, and the website. Healthy Blue sends letters and postcards to remind members about immunizations and screenings that are due and offers assistance in scheduling appointments and transportation for these services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					Timeliness of prenatal care is tracked with HEDIS monitoring of pregnant members. The Member Handbook describes the pregnancy program for women to receive education on services that can assist in achieving a healthy pregnancy. Identified pregnant women are registered for the New Baby, New Life SM program.
III E. Member Satisfaction Survey						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Healthy Blue contracts with DSS Research, a certified CAHPS survey vendor, to conduct the adult and child surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					DSS Research summarizes and details all results from both surveys. The analysis and implementation of interventions to improve member satisfaction is conducted by the Quality Improvement Committees. The QI Evaluation displayed an analysis of data and action steps to achieve higher scores for member satisfaction.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The Quality Improvement Committee (QIC) minutes from October 2019 and 2020 QM Work Plan indicated results were presented and action plans were initiated to address problematic survey measures.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO reports the results of the member satisfaction survey to providers.	X					Survey results were offered to providers in the CAHPS Results Provider Notification Letter.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The CAHPS Outcome report was presented to the QIC in October 2019 and to the SQIC in November 2019.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC_GAXX_015, Grievance Process: Members, describes requirements and processes for receiving and resolving member grievances.
1.1 The definition of a grievance and who may file a grievance;		X				Information about the definition of a grievance and who may file a grievance is found in Policy SC_GAXX_015, the Provider Manual, and the Member Handbook. Chapter 11 (Member Grievances and Appeals) of the Provider Manual, page 93, states, "For definitions applicable to this section, please refer to Healthy Blue website…" However, the Healthy Blue website does not include a glossary and the information about grievances does not include definitions of terminology. Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document do not address the requirement that written consent is required for a representative

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to file a grievance on a member's behalf. Discussion during the onsite teleconference confirmed that the health plan does not require written consent for member representation in the grievance process but that they accept verbal consent from the member. *Quality Improvement Plan: Revise the Healthy Blue website to include definitions of grievance terminology. If the terminology is not added to the website, revise the Provider Manual to include grievance terminology definitions. Revise grievance processes to include the requirement for written member consent for a grievance to be filed on a member's behalf. Update Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include this requirement. Refer to the SCDHHS Contract, Section 9.1.1 and 9.1.1.1.2 as well as 42 CFR §438.402 (c) (1) (ii).*
1.2 Procedures for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of a grievance;		X				Grievance resolution and notification timeframes are documented in Policy SC_GAXX_015, the Member Handbook, and the Provider Manual. The "Your Grievance and Appeal Rights as a Member of Healthy Blue" document does not

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						address extensions of grievance resolution timeframes. Neither the Grievance Extension Notification letter (BSC-MEM-0738-18) nor the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document, which is sent as an attachment to grievance letters, informs the member of the right to file a grievance if he or she disagrees with an extension of the grievance resolution timeframe. *Quality Improvement Plan: Revise the Grievance Extension Notification letter (BSC-MEM-0738-18) or the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include information that a member may file a grievance if he or she disagrees with extension of the grievance resolution timeframe. Revise the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include information about extensions of grievance resolution timeframes.*
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Policy SC_GAXX_015 states Healthy Blue submits a quarterly grievance log to SCDHHS and retains logs for at least 10 years. If any litigation, claim negotiation, audit, or other action involving

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						grievance documents or records has been started, the records are retained until the completion of the action and resolution of the issues which arise from it or until the end of the regular 10-year period, whichever is later.
2. The MCO applies grievance policies and procedures as formulated.	X					Grievance file review findings include: •Two grievances were not resolved within the 30-day timeframe documented in Policy SC_GAXX_015. Discussion with the health plan staff confirmed these were untimely and that there was no extension initiated for these grievances. •One grievance was not acknowledged within the 5-day timeframe documented in Policy SC_GAXX_015. Health plan staff acknowledged this finding during the onsite teleconference. •One grievance was created in response to a letter from an attorney regarding subrogation for a motor vehicle accident. Prior to the determination that this was not a grievance, a grievance acknowledgement letter was sent to the member. Health plan staff stated during onsite discussion that someone should have communicated this mistake to the member; however, there is no indication this communication occurred. *Recommendation: Ensure grievances are acknowledged and resolved within the timeframes documented in Policy SC_GAXX_015. If incorrect grievance notices are sent to*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members, ensure there is follow-up to inform the member of the mistake.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Quarterly reports that track and trend grievances are provided to the Service Quality Improvement Committee (SQIC). The SQIC reviews the grievance information to identify and address trends. A separate report capturing grievances about providers and provider offices (accessibility, safety, sanitation and appearance, handicapped access, adequacy of waiting/public rooms, adequacy of examination rooms, posting of office hours, adequate patient record-keeping system, and adequate system of maintaining patient appointments) is sent to the Credentialing Department on a bi-weekly basis. CCME's review of SQIC minutes confirms presentation and discussion of grievance reports.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					Healthy Blue maintains a Quality Improvement (QI) program with the overall goal to improve the quality and safety of clinical care and services provided to members. The 2020 Medicaid Quality Management Program Description describes this program with specific goals and the program's structure, scope, and methodology. The program description is updated annually, reviewed, and approved by the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC).
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Monitoring of over and underutilization data is addressed in the Utilization Management Program Description.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annually Healthy Blue develops a QI work plan to guide and monitor activities for the year. The 2019 and 2020 work plans were provided. Each work plan identified specific activities, responsible party, and specific date for completion. The descriptions noted in the Objective/Activity column were general and did not contain the specific objectives. The work plan referred the reader to the NCQA 2020 HP Standards and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Guidelines for complete details and requirements. There was no mention of state requirements. Also, the dates listed in the Specific Date for Completion and the Committee and Schedule Review and Approval Date columns were the same for all activities listed on the work plan. *Recommendation: Include the details and state requirements for each activity listed on the QI work plan. Also, correct the dates of completion for each activity.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC) have been established to oversee the QI program and activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					A variety of network providers appointed by the Medical Director and approved by the CQIC and the board of directors serve on the CQIC. Current membership shows six network providers serve on the CQIC. Their specialties include family medicine, OB/GYN, emergency medicine, and pediatrics. A quorum is met with the attendance of three network providers.
3. The QI Committee meets at regular quarterly intervals.	X					According to the committee charters, the CQIC and SQIC meet as necessary, but no less than quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting. Documentation reflects committee discussion points and decisions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Healthy Blue uses Inovalon, a certified software organization, for calculation of HEDIS rates, and the validation found all requirements were met. The comparison from the previous year to the current year revealed a strong increase in Pharmacotherapy Management of COPD Exacerbation, Diabetes Monitoring for People with Schizophrenia, and Use of First Line Psychosocial Care for Children on Anti-Psychotics. There were no measures with a substantial decline of greater than 10%. Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3*.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Healthy Blue submitted two projects. They included Access and Availability of Care and Comprehensive Diabetes Care.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The recommendations for last year included initiating or revising interventions for the Access and Availability of Care PIP, as rates were not improving for the adult access to preventive (AAP) services HEDIS measure nor the CAHPS composite measure. The interventions of home visits, automated texting, and enhanced IVR did not improve AAP rates, as they showed a decline. The CAHPS rate did improve. It was noted in the documentation this PIP would be discontinued, although the report noted that access rates would be monitored. The October 2019 CQIC minutes noted that

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						it will be retained. Healthy Blue indicated they did not plan to retire the PIP but to revise the PIP. For the Comprehensive Diabetes Care PIP, the results for Indicator one appears to be inaccurately reported, as the rate is different at baseline and remeasurement one, but the numerators are the same (349). The remeasurement one numerator needs to be adjusted to reflect the rate. There were no new interventions noted for 2019 and analysis of numbers for 2019 were not included in the report. Both scored in the "High Confidence in Reported Results" range. Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*. *Recommendation: Continue to monitor the adult access to preventive (AAP) services even with pending closure of PIP. Correct the errors noted in the Comprehensive Diabetes Care PIP.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Network providers receive QI performance data through the Provider Report Card and Care Opportunity Reports.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					To evaluate the effectiveness of the QI program, Healthy Blue conducts an evaluation annually. The draft Medicaid Quality Management Program Evaluation for the 2019 Work Plan was provided. The evaluation included results of the quality activities conducted in 2019, any barriers identified, and opportunities for improvements.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Utilization Management Program Description outlines the goals, scope, and staff roles for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina. Several policies such as Policy and Procedure Clinical Criteria for Utilization Management Decisions - Core Process and Policy and Procedure Clinical Criteria for Utilization Management Decisions, provide guidance on utilization management (UM) processes and requirements. The program description was last reviewed and approved by the Health Care Services Committee (HCSC) on November 25, 2019. The Anthem Pharmacy Program Description outlines the pharmacy program is managed by IngenioRx.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeliness guidelines for UM determinations are documented in the UM Program Description, Policy SC_UMXX_117, Decision and Notification Timeframes, the Member Handbook, the Provider Manual, and Policy A16, Health Plan Pharmacy Benefits, Exhibit P (SC Pharmacy Services).
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Policy SC_UMXX_065, Separation of Financial and Medical Necessity Decision-Making, describes that Healthy Blue does not provide incentives to reward restriction of medical care to members.
1.7 the mechanism to provide for a preferred provider program.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Roles for the Amerigroup Clinical Operations Chief Medical Officer and Amerigroup Medical Directors, for physical and behavioral health services, are described in the UM Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting UM reviews, and participating on plan committees. Imtiaz Khan, DO, is currently the Medical Director and Dr. Jorge Hernandez-Chaple is the BH Medical Director. Additionally, Jonathan Jones, the Pharmacist

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Director, works in collaboration with the HCS Department and oversees the Pharmacy Program.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					Annual review and approval of the UM Program is the responsibility of the Amerigroup Medical Director, the Clinical Quality Improvement Committee, and the Service Quality Improvement Committee. The Utilization and Case Management Program Annual Evaluation includes analysis of UM, CM, DM, and pharmacy resources, metrics, and key performances. The 2019 Utilization and Case Management Program Annual Evaluation was approved by the Clinical Quality Improvement Committee on 4/15/2020.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					The UM Program Description and policies such as Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, and Policy and Procedure Clinical Criteria for Utilization Management Decisions describe how Healthy Blue utilizes objective and evidenced-based guidelines, protocols, and criteria to determine appropriate medical necessity decisions and screenings, including but not limited to, MCG™ Guidelines, medical policies and clinical UM guidelines, and AIM Specialty Health guidelines for physical health, behavioral health, and durable medical equipment. Individual circumstances and the local delivery system are considered when determining medical appropriateness.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies, the Provider Manual, and on Healthy Blue's website. Additionally, the criteria for utilization are communicated in the Member Handbook. The Abortion Statement and Consent for Sterilization forms are found on the provider website under "Resources." Unlike the Provider Manual, the website does not include instructions for obtaining the Surgical Justification Review for Hysterectomy Form HHS-687 from the SCDHHS website. *Recommendation: To be consistent with the Provider Manual, include instructions on the provider website for obtaining the Surgical Justification Review for Hysterectomy Form HHS-687 from the SCDHHS website.*
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Healthy Blue conducts annual inter-rater reliability testing (IRR) for clinical staff reviewers, physicians, non-physicians, and BH clinicians as defined in Policies SC_UMXX_120, Nurse Inter-Rater and SC_UMXX_078, Physician Inter-rater Reliability Assessment. Policy A31, Pharmacy Inter-Rater Reliability, describes how the Pharmacy Services Department conducts quarterly IRR audits. Corrective action plans are established for physicians scoring below the 80% benchmark and for non-physicians and pharmacists scoring below the 90% benchmark. IRR results are reported to respective department leaders and annually to the SQIC and CQIC. The 2019 UM CM Program Evaluation indicate all nurse and BH reviewers, as well as physician reviewers, achieved passing scores above the respective goals after remedial training was completed.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions are noted on the PDL, which identifies over-the-counter (OTC) medications that are covered, and negative PDL changes are posted on the website. The National Pharmacy and Therapeutics (P&T) Committee Formulary Updates Summary confirms Healthy Blue publishes negative PDL changes to the website at least 30 days prior to the effective date.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Anthem's Pharmacy and Therapeutics Process consists of two sub-committees that function as a checks-and-balances system. The P&T Committee makes decisions regarding PDL management activities and the Value Assessment Committee (VAC) establishes formulary tier assignments that appropriately balance clinical, financial and customer impact. Policy A45, Pharmacy Benefits Transition of Care Continuity of Care, and Policy SC_PMXX_020, Prescription Transition Period, correctly indicate Healthy Blue will honor prescriptions for new members who come into the health plan for up to 90 days while a prior authorization is pending. However, Policy SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care, states that the plan will honor prior authorized prescriptions for up to 60 days. Pharmacy staff confirmed this was previous contract language that was not updated. *Recommendation: Update Policy SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care, to include current requirements that Healthy Blue will honor existing prescriptions needing a Prior Authorization (PA) under the new plan's formulary for a period of no less than ninety (90) days, as specified in the Policy and Procedure Guide for Managed Care Organizations, Section 4.2.21.3.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					For medications within the pharmacy benefit that require prior authorization, Healthy Blue ensures members are provided a 72-hour supply of medications while the prior authorization is pending, as described in Policy SC_PMXX_005, Provisional Drug Supply Management. Additionally, this requirement is documented in the Pharmacy Services Program Description, Policy SC_PMXX_025, Medicaid Pharmacy Lock-In Program and A08 - Pharmacy Prior Authorization. The Provider Manual and the provider website describe the requirement for specialty medications and indicates Healthy Blue allows the initial supply to be provided from a local pharmacy if required. Policy A08 - Pharmacy Prior Authorization describes the process used by pharmacy staff to resolve authorization issues, however, the requirement that members should not be involved or participate in the resolution of a prescription issue is not included. Pharmacy staff confirmed that members are not involved in the resolution process for medications requiring authorization. *Recommendation: Edit Policy A08 - Pharmacy Prior Authorization to include the requirement that the plan shall not require the member's involvement or participation in the resolution of a prescription issue related to the issuance of a prior authorization, as specified in the SCDHHS Contract, Section 4.2.21.3.3.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy SC_UMXX_101, 24-hour Access to Emergency Department Services, addresses all required Emergency and Post Stabilization services listed in the *SCDHHS Contract, Section 4.2.11.2.*
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					The UM Program Description defines required qualifications for staff at various clinical decision-making levels.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with Policy SC_UMXX_117, Decision and Notification Timeframes, the UM Program Description, and SCDHHS Contract requirements. As reported in the 2019 UM CM Program Evaluation, Healthy Blue exceeded its goal of 95% for Prior Authorization turn-around-times for medical and BH service requests. Performance rates ranged from 96.9% to 99.8% for both urgent and standards requirements.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files reflect review by a medical director when UM Clinical Staff can not approve requests that do not meet medical necessity criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Adverse benefit determinations are made by appropriate physician specialists as outlined in Procedure MHSC-HCS-UM-364, Appropriate Professionals Making UM Decisions. The list of UM physician reviewers shows a diversity in clinical specialties.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					CCME's review of denial files confirmed review staff follow processes outlined in the Clinical Information for Utilization Management Reviews - Core Process Policy. Adverse benefit determinations were timely and denial notices contained required information in language that can be easily understood.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC_GAXX_051, Member Appeal Process, and the UM Program Description outline the appeals processes and instructions are provided in the Provider Manual and Member Handbook.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Definitions of the terms "adverse benefit determination" and "appeal," along with information about who may file an appeal, are described in the UM Program Description, the Provider Manual, and the Member Handbook. These documents appropriately indicate that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf.
1.2 The procedure for filing an appeal;	X					The procedure for filing a member appeal is documented in Policy SC_GAXX_051, Member Appeal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Process, the Provider Manual, and Member Handbook. The Member Appeal Request Form and the Member Appeal Representative Form are available on the member website, although not easily accessible. However, the member website does not provide instructions or information on appeals. *Recommendation: Update the website to include information and instructions on the appeals process. Post the Member Appeal Request Form and the Member Appeal Representative Form in a more accessible location on the website.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy SC_GAXX_051, Member Appeal Process, the Member Handbook, and the Provider Manual appropriately state the standard and expedited appeal resolution and notification timeframes.
1.6 Written notice of the appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					Requirements for continuation of benefits while an appeal is in progress are correctly documented in Policy SC_GAXX_051, Member Appeal Process, the Provider Manual, the Member Handbook, and letter templates.
2. The MCO applies the appeal policies and procedures as formulated.			X			CCME's review of appeal files revealed several issues: •Although the Appeal Representative Form is included with acknowledgement letters, appeal requests submitted on behalf of the member were processed without obtaining signed Appeal Representative Forms, as specified on page 4 of Policy SC_GAXX_051. During the onsite teleconference, Healthy Blue staff confirmed signed authorized representative forms are required for appeal cases. •Expedited requests were processed as standard requests without notifying the member that the request was downgraded to a standard appeal timeframe of 30 days, as noted on page 6 of Policy SC_GAXX_051. During the onsite Healthy Blue confirmed two appeal files were received as expedited requests and entered as standard requests in error. •One appeal file did not include documentation that the appeal was reviewed by or discussed with a Medical Director, as specified in Policy SC_GAXX_051, Member Appeal Process. During the onsite, Healthy Blue revealed there was a system routing error that prevented the appeal from being assigned to the Medical Director and the nurse documented the decision rationale on behalf of the Medical Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additional issues identified with appeal case files include: •Member letters mailed with case file documents correctly states, "You can give evidence, testify, and make legal or factual arguments in person and in writing about your case. You must do so before your appeal request is resolved." However, the letter does not indicate a timeframe or deadline when the member must respond with additional information. •Case file letters and Appeal Resolution notices were dated within a few days of each other, thus not allowing the member adequate time to respond and present new evidence before the case is resolved. For example, in appeal file #2 the case file letter is dated 12/23/19 and the resolution notice is dated 12/30/19, and in appeal file #6 the case file letter is dated 1/6/20 and the resolution notice is dated 1/7/20. •Appeal case files were sent to members without documentation that a signed medical record release was obtained, as specified on page 1 in Policy SC_GAXX_051. During the onsite teleconference, staff confirmed case files are automatically mailed members. *Quality Improvement Plan : Ensure staff follow all appeals processes outlined in Policy SC_GAXX_051, Member Appeal Process, such as: obtaining signed Appeal Representative Forms, notifying members when an expedited appeal request is downgraded to*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						a standard request, and ensuring medical necessity files are reviewed and documented by a physician. *Recommendation: Edit case file letters to include a timeframe or deadline when members must respond and present new evidence before the case is resolved. Revise Policy SC_GAXX_051, Member Appeal Process, to include the process used by Healthy Blue for mailing all appeal case files to members and obtaining signed medical record release forms. Ensure the documented process specifies the timeframe within which Healthy Blue mails the appeal case files to members.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy SC_GAXX_051, Member Appeal Process, states all appeals are tracked and trended for analysis, and the analysis is reported to the SQIC. The Utilization and Case Management Program Annual Evaluation indicates 2019 performance of appeal acknowledgement letters was 88.7%, which is below the 95% goal, and member resolution letters achieved 98.8% compliance, which is above the 95% goal. Analysis suggests routing issues are contributing to low performance rates.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The Population Health Program Description and Case Management (CM) Program Description outline the framework for case management/care coordination

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and program goals, objectives, lines of responsibility, and operations for physical and behavioral health services. Additionally, the Provider Manual and Member Handbook provide descriptions of the Case Management program.
2. The MCO has processes to identify members who may benefit from case management.	X					The CM Program Description and policies, such as Policy GBD CM-019, Case Management Program Case Identification and Population Assessment, describe methods for how eligible members are identified and referred into case management. In addition to referral guidelines and results from predictive modeling, Healthy Blue uses review of clinical claims, health risk assessment results, medical records, and utilization management data to identify members who can benefit from case management. Healthy Blue identifies and prioritizes candidates for Case Management through a Continuous Case Finding (CCF) process.
3. The MCO provides care management activities based on the member's risk stratification.	X					Healthy Blue's approach to care management processes is outlined in the Population Health Program Description and the CM Program Description. The population health program stratifies members into three risk levels. Additionally, members are sorted by risk and stratified into five intervention groups ranging from zero (0) to four (4) which corresponds to the level of CM.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Healthy Blue has processes to refer members, such as those with alcohol and substance abuse and children in foster care, to Targeted Case Management services provided by SCDHHS, as described in Policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SC_CAXX_108, Targeted Case Management - Identification and Referral of Eligible Members. Case Managers utilize the Medical Management System documentation system to assess, coordinate and manage care for members. This system has evidence-based and clinical decision-making tools that are consistent with NCQA and the Case Management Society of America (CMSA)s.
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy SC_CAXX_110 states, "Approval or denial for Continued Access to Care is made on the basis of the member's specific clinical condition, medical needs, and circumstances. With the exception of maternity, the determination is not based on the member's diagnosis." Additionally, polices SC_CAXX_097, Transition to Other Care When Benefits End, and SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care, correctly addresses transition of care requirements.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					The Health Care Management (HCM) Case Management Manager serves as the Transition Coordinator.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					Annually, Quality Committees evaluate the CM Program to ensure goals and performance metrics meet standards and remain consistent with strategic plans. The CM Program Description states evaluation of CM performance measures includes, but is not limited to, evaluation of results of the case management quality case review process, review of quality and aggregate data from member satisfaction survey reports, and complaints. Case management metrics are reported in the Utilization and Case Management Program Annual Evaluation. Monthly clinical case management audits are conducted to ensure individual case managers are following established processes and to identify opportunities for improvement.
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate CM activities are conducted as required and Case Managers follow policies to conduct the appropriate level of case management. During the onsite teleconference, CCME discussed that PCP communication was not reflected in sampled files. Healthy Blue staff confirmed the standard CM process does not include frequent communication with providers, and PCP contact is conducted as described in Policy SC_CAXX_106, Case Management Documentation.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					Policy SC UMXX 061, Under- and Over-Utilization of Services – Monitoring, is in place to ensure that Healthy Blue monitors and analyzes relevant data to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						detect and correct patterns of potential or actual inappropriate under- or over-utilization which may impact health care services, coordination of care, and appropriate use of services and resources.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Healthy Blue analyzes data on the following topics regarding utilization: •ER Visits •Inpatient Setting- Discharges/1000 member months •Frequency of Selected Procedures- Back Surgery, Bariatric Weight Loss Surgery, and Tonsillectomy Healthy Blue analyzed and monitored utilization data and offered recommendations based on findings for the services indicated above. This was evident in committee minutes, in the 2018 Utilization and Case Management Program Annual Evaluation, and in the 2018 Under and Over Utilization report.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Policy HP 003-12, Oversight of Delegated Activities states, "All delegated organizations have a written, signed agreement designating the delegated activities with the compliance and oversight requirements included." CCME's review of a sample delegation agreement confirmed the agreement includes the activities delegated, responsibilities of both the health plan and the delegate, reporting requirements, information about confidentiality, sub-delegation, and possible actions taken in response to substandard or non-performance.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				Processes and requirements for delegation oversight and monitoring are included in Policy HP 003-12, Oversight of Delegated Activities. Additional policies that address delegation monitoring and oversight include Policy MCD-10, Medicaid Delegated Credentialing, Policy A65, Pharmacy Benefit Manager (PBM) Performance Oversight, and the Utilization Management - Medicaid Delegation and Oversight policy. All potential delegates are subjected to a pre-delegation assessment of their operations, policies, reporting capabilities, and ability to perform the activities to be delegated. Once a delegation agreement is in place, annual oversight is conducted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of each delegate. The annual review includes an assessment of the delegate's compliance with accreditation standards, contractual requirements, written policies and procedures, and quality activities related to the delegated functions and activities. For utilization and credentialing/recredentialing activities, the annual oversight includes file review to assess the delegate's compliance with contractual requirements, State and Federal regulations, and accreditation standards. In addition to annual oversight, delegates provide reports of delegated activities to the health plan on a predetermined schedule. If any deficiencies are identified, a corrective action process is initiated, and the delegate is informed in writing of the corrective action required and the timeframe for completion. CCME's review of delegate oversight documentation confirmed that, overall, appropriate processes are followed. It was noted that the MCO Credentialing File Review Workbook used to assess credentialing delegates does not indicate whether delegates are monitored for querying the National Practitioner Databank and the National Plan and Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing. *Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for conducting required queries of the National*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Practitioner Databank and the National Plan and Provider Enumeration System. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Healthy Blue ensures pediatric immunization requirements are monitored by instructing providers to bill appropriate vaccine codes, as described on page 62 of the Provider Manual. Additionally, providers are informed that Healthy Blue monitors compliance with immunization requirements by reviewing PCP immunization rates through HEDIS and annual medical record reviews.
1.2 performing EPSDTs/Well Care.	X					Healthy Blue uses several methods to ensure EPSDT requirements are tracked, such as listing billing requirements for EPSDT services in the Provider Manual and conducting annual medical record audits. Policy SC_PCXX_009, Pediatric Preventive

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, states Healthy Blue ensures providers are educated about EPSDT requirements through online provider bulletins and information posted on the provider website. The 2019 Quality Management Program Evaluation reported performance improvements for the Well-Child Visits in the First 15 Months measure. However, minimal improvement was noted for the W15 Well-Child Visits measure and static or decreased performance for the W34 Well-Child Visits and AWC Adolescent Well Care Visits measure. During the onsite teleconference, Healthy Blue staff discussed barriers and areas of opportunity to address low performing measures. *Recommendation: Continue to monitor and address barriers contributing to providers not completing required immunization and EPSDT services.*
2. Core benefits provided by the MCO include all those specified by the contract.	X					Healthy Blue provides core benefits as required by SCDHHS. Healthy Blue implemented the BabyNet program on October 1, 2019 and has information and respective forms available on the website for members and providers.
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					